Alpha-1 Antitrypsin Deficiency Referral Form

MedPro Rx™
A DIPLOMAT® COMPANY

Phone: (888) 571-3100 ▪ Fax: (800) 582-9315

Date_____

Demographics

Patient Name_____

Address _____

City _____ State_____ Zip_____

Date of Birth_____Sex: ☐ Male ☐ Female

Phone: (*h*)_____ (w)_____

(*c*)_____ HT:_____ WT:_____

SS#: _____

Next of Kin:_____

Prescribing Physician

Name _____

Address _____

City_____State_____ Zip _____

Phone_____ Fax _____

NPI#_____ Office contact _____

UPIN # _____

License #_____ Phone (if different)_____

I have read this entire form and verify to its accuracy ☐ Yes

Prescriber Signature: _____
Dispense as written

Prescriber Signature: _____
Substitution allowed

Date: _____

Insurance Information: *MAY FAX DEMOGRAPHIC SHEET*

Primary Insurance _____

Member ID# _____ Group #_____

Policy Holder _____ Relationship _____

Secondary Insurance_____

Member ID#_____ Group #_____

Policy Holder _____ Relationship_____

Diagnosis

Primary Alpha-1 antitrypsin deficiency ICD-9 273.4 Secondary_____ ICD-9_____

Diabetic ☐ YES ☐ NO Antitrypsin Deficiency Blood Testing Completed? ☐ YES ☐ NO IgA Level:_____

Has the patient received augmentation therapy before? ☐ YES ☐ NO Associated medical conditions:_____

Serum AAT level:_____ ☐ mg/dL or ☐ pM Date:_____ Phenotype ☐ PiZZ ☐ PiSZ ☐ PiMZ ☐ Other:_____

PFT:FEV % pred.:_____ O2: therapy_____ L/min Date:_____ Smoking History ☐ Yes ☐ No Smoking Cessation Date: _____

Physician Orders

Drug Name Zemaira® [alpha-1 proteinase inhibitor (Human)]

Patient Wt._____kg (1kg = 2.2 lb) Dose*_____mgs Frequency* ☐ Weekly ☐ Other_____

¶The recommended dose for Zemaira is 60 mg/kg of body weight, administered once weekly. Actual dose may vary by up to 10% (plus or minus) based on available assay size from the drug manufacturer.

Premedication(s):_____

Delivery Method:

☐ As tolerated by patient, not to exceed 0.08 mL/kg/min

☐ Other: _____

Vascular Access Device: ☐ Peripheral Catheter ☐ Central Catheter

Flush Orders: ☐ 0.9% Sodium Chloride 5-10mL before and after Zemaira and PRN ☐ Heparin 100 units/mL 5mL post-infusion and PRN

☐ Skilled Nursing Visits to establish venous access, administer medication as prescribed, assess patient status and response to therapy.

☐ Standard Supplies As Necessary
☐ Anaphylaxis Kit Per Protocol

☐ Allergies_____

Has the patient received Zemaira previously? ☐ Yes ☐ No

If yes, date of last dose: _____

Anticipated start date: _____

☐ First dose to be given in the home

Ship product to:
☐ MD office (MD accepts on behalf of patient)
☐ Patient's home

MedPro Rx, Inc. is compliant with HIPAA Guidelines

Please CLICK HERE to email this form automatically, or attach manually to: referrals@medprorx.com

Or Fax Completed Copies of the Following to MedPro Rx @ 1-800-582-9315: (1) Referral Form and (2) Your Insurance Card(s)