

Patient Demographic Information

Patient Name (First/Last) _____ Date of Birth (DOB) _____
 Address _____ Social Security Number _____
 City _____ State _____ Zip _____ Home Phone _____

Insurance Information (Attach Card)

Primary Insurance _____ Phone _____
 Subscriber _____ DOB _____ Subscriber ID # _____ Policy/Group # _____
 Secondary/Medigap _____ Phone _____
 Subscriber _____ DOB _____ Subscriber ID # _____ Policy/Group # _____

Diagnosis/ Medical Assessment

Primary Diagnosis: Alpha₁ antitrypsin deficiency ICD.9 Code 273.4
 Secondary Diagnosis: _____ ICD.9 Code _____
 Serum AAT level: _____ mg/dL OR _____ mM Date: _____
 PFT: FEV1 % Pred. _____ O₂ Therapy _____ L/min Date: _____
 CXR/CT Results: _____ Date: _____
 Phenotype: PiZZ PiSZ PiMZ Other _____
 Smoking History: Yes No Previous smoker/date stopped: _____
 Date last office visit: _____ Date last hospitalization: _____
 Notes: _____

Therapy

Prescribed Therapy: ARALAST [alpha₁-proteinase inhibitor (human)] Procedure Code _____
 Patient Weight: _____ kg (2.2 lb = 1 kg) Ordered Dose: _____ mg Frequency: weekly other _____
 Days Supply: _____ Refills (Months): _____
 Infusion Location: Home Hospital Physician Office
 Infusing Facility: _____
 Contact Name: _____ Phone: _____

Preferred HCP select one:
 Coram Accredo Caremark
 No Preference

Prescriber

Physician Name _____ License # _____
 Address _____ Provider # _____
 City _____ State _____ Zip _____ DEA # _____
 Phone _____ Fax _____ Office Contact _____
 Signature _____ Date _____

I certify that the prescribed therapy is medically necessary for the treatment of Alpha-1-antitrypsin deficiency and that the above information is accurate to the best of my knowledge and belief. I further certify that I have obtained the patient's consent to release this information for the patient's enrollment in the Aralast AATmosphere program. By my signature above, I authorize the Aralast AATmosphere program to (1) provide any information on this form to the insurer of the above named patient for enrollment/verification purposes and (2) forward the above prescription information, by fax or other mode of delivery, to the patient's pharmacy. I understand that any information released will be used only for the purposes for which it has been provided.

ARALAST [Alpha₁-Proteinase Inhibitor (Human)] is indicated for chronic augmentation therapy in patients having congenital deficiency of A₁-PI with clinically evident emphysema. ARALAST is not indicated as therapy for lung disease patients in whom congenital A₁-PI deficiency has not been established.

Important Safety Information

- ARALAST is contraindicated in individuals with selective IgA deficiencies (IgA level less than 15mg/dL) who have known antibody against IgA, since they may experience severe reactions, including a severe, potentially life-threatening allergic reaction to IgA, which may be present.
- The most common symptoms during the clinical study were headache (0.3%) and sleepiness (0.3%). Post-market adverse event data have indicated reports of infusion site pain associated with the administration of ARALAST.
- Pregnancy Category C, reproduction studies have not been conducted with ARALAST.
- As with all plasma-derived therapeutics, the potential to transmit infectious agents cannot be totally eliminated.

Please see enclosed ARALAST Prescribing Information for full prescribing details.