

Alpha-1 Referral Form



Referral Date: _____ **Please fax copy(s) of patient's insurance card(s) with referral*

Patient Information			
Patient Name	DOB	Sex <input type="checkbox"/> M <input type="checkbox"/> F	SSN
Address		Phone #	
City / State		Employer	
Primary Insurance		Phone #	
Name of Insured		Relationship	
Insured SS#	DOB	Employer	
Group #		Policy #	
Secondary Insurance		Phone #	
Name of Insured		Relationship	
Insured SS#	DOB	Employer	
Group #		Policy #	

May we contact the patient regarding insurance benefits and product delivery? Yes No

Medical Information			
Primary Diagnosis	Weight <input type="checkbox"/> lbs. <input type="checkbox"/> kg	Height <input type="checkbox"/> in <input type="checkbox"/> cm	
Allergies		Diabetic: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Antitrypsin deficiency blood testing completed? <input type="checkbox"/> Yes <input type="checkbox"/> No		IgA Level	
Has the patient ever received augmentation therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which one: <input type="checkbox"/> Aralast <input type="checkbox"/> Prolastin <input type="checkbox"/> Zemaira			

Medication Orders	
Alpha-1 product: <input type="checkbox"/> Zemaira®	Refills: _____ times (as allowed by state or payor requirements)
Dosage: <input type="checkbox"/> 60 Mg per Kg (+/- 10%) Weekly <input type="checkbox"/> Other regimen: _____	Vascular Access Device: <input type="checkbox"/> Peripheral Catheter <input type="checkbox"/> Central Catheter Type _____ # of lumens _____
Delivery Method: Gravity	Administration Rate/Time: <input type="checkbox"/> As tolerated by patient, not to exceed 0.08ml per kg per minute <input type="checkbox"/> Other: _____
<input type="checkbox"/> Pre-medication: _____ <input type="checkbox"/> ELA-Max4% 5 grams applied topically to site prior to venous accessing	Is this the first dose? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, date first dose given: _____ Next dose: _____
Accredo Therapeutics Nursing Services Requested? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Skilled nursing visit to establish venous access, patient education related to therapy & disease state, administer medication as prescribed, assess general status, and response to therapy. Visit frequency based on prescribed dosage orders.	
Flush Orders:	<input type="checkbox"/> Normal Saline 1-50 ml before and/or after IV med. and prn line maintenance <input type="checkbox"/> Heparin 100 units per ml 3-5 ml post infusion and prn line maintenance
Anaphylactic Kit maintained in the patient's home:	<input type="checkbox"/> Diphenhydramine 25-50mg PO prn allergic reaction <input type="checkbox"/> Epinephrine 1:1000, 0.3 – 0.5 ml subcutaneous or IM prn anaphylaxis.
<input type="checkbox"/> Dispense ancillary supplies as needed to establish IV and administer medication.	
Additional Requirements:	

Physician Information			
Prescribing Physician Name	Address		
License #	DEA#	NPI#	UPIN#
Phone Number	Fax Number		Office Contact Name
PCP Name (if applicable or different from prescribing MD)	Practice Specialty		Phone Number
Referral source: (please check one) <input type="checkbox"/> Prescribing physician <input type="checkbox"/> AlphaNet <input type="checkbox"/> Patient self-referral <input type="checkbox"/> Other: _____			

**If Nursing Services will be required for therapy administration, the home health nurse will call for additional orders per state regulations.*

Physician Signature _____ Date _____

For questions or if you wish to submit a referral, please contact Accredo Therapeutics at

Phone: 1.866.6Alpha-1 Fax: 1.866.233.7151

ATX
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