DOCTOR/PRESCRIBER

Alpha$_1$-Proteinase Inhibitor Enrollment Form

1. DOCTOR/PRESCRIBER FILL OUT AND FAX TO: 1-866-413-4139 or Call: 1-866-413-4138

- Faxes will only be accepted from a doctor's office.
- Class II medications cannot be faxed.

Patient Information ☐ New Rx ☐ Refill

Name: ______________________ Phone #1: ____________ Phone #2: ____________
Address: ______________________ Allergies: ______________________ ☐ No Known Allergies
City: ____________ ST: _____ Zip: ________ Health Conditions: ______________________
Date of Birth (mm/dd/yyyy): __ __/__ __/__ __ __ __ Expected Start Date: __ __/__ __/__ __

Statement of Medical Necessity

Patient Weight: ______ ☐ lbs ☐ kg Primary Diagnosis: ______________________ **ICD9 Code:** ______________
Genotype: ☐ PiMM ☐ PiMS ☐ PiMZ ☐ PiSS ☐ PiSZ ☐ PiZZ ☐ Null ☐ Not Known
Serum IgA level: _____ mg/dL Date taken: __ __/__ __/__ __ ☐ Patient is on O_2 therapy: _____L/min
Serum AAT level: _____ mg/dL Date taken: __ __/__ __/__ __ ☐ Patient has a smoking history. Date Stopped: __ __/__ __/__ __
FEV1: _____ Date taken: __ __/__ __/__ __ ☐ Patient has been treated with prior therapy: ______________

Drug Delivery Information

If this drug requires Prior Authorization, please send appropriate documentation (notes, test results, etc.)

☐ In Office Delivery ☐ Home Delivery for Self Injection/Administration
☐ Home Delivery for Home Health Administration ☐ Outpatient Clinic
Other: ______________________
Contact: ______________________
Phone #: ______________________
Address: ______________________

Insurance Information

Complete here or fax a copy of the patient's insurance card (both sides). Medicare card is required.

Primary: ______________________ Secondary: ______________________
Insured: ______________________ Insured: ______________________
ID #: ____________ Group #: ____________ ID #: ____________ Group #: ____________
Phone #: ____________ Rx Drug Card #: ____________ Phone #: ____________ Rx Drug Card #: ____________
Rx Bin #: ________ Rx PCN #: _____ Rx Grp #: ________ Rx Bin #: ________ Rx PCN #: _____ Rx Grp #: ________

Doctor/Prescriber Information

NPI # is mandatory. DEA # is required if the prescription is for controlled substances or Medicare/Medicaid.

Name: ______________________ Office Contact: ______________________
Address: ______________________ NPI #: ____________ DEA #: ____________
City: ____________ ST: _____ Zip: ________ Phone #: ____________ Fax #: ____________

2. COMPLETE THE FOLLOWING Rx FORM –OR– TAPE Rx HERE

Rx

Date: __ __/__ __/__ __

Drug Name/Form/Strength	Quantity	Directions for Use	Refills
☐ Aralast® NP			
☐ Glassia™			
☐ EpiPen® ☐ EpiPen Junior®			
Other:			

Needles Gauge: _____ Inches: ___ Quantity: ___ Refills: ___ **Syringes** Volume: _____ Inches: ___ Quantity: ___ Refills: ___

X ______________________
Doctor/Prescriber Signature – Dispense as Written
Stamped signatures cannot be accepted

X ______________________
Doctor/Prescriber Signature – Substitution Permissible
Stamped signatures cannot be accepted

Federally approved, generic-equivalent medications will be dispensed for brand-name medications unless otherwise directed by the patient, physician, or health plan.

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