GLASSIA®

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____

Address: _____

City, State, Zip: _____

Phone: _____ Alt. Phone: _____

Email: _____ SS#: _____

Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____

Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____

State License: _____

NPI #: _____ Tax ID: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Office Contact: _____ Phone: _____

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____

Plan #: _____

Group #: _____

RX Card (PBM): _____

BIN: _____ PCN: _____

Secondary Insurance (If Applicable): _____

Plan #: _____

Group #: _____

RX Card (PBM): _____

BIN: _____ PCN: _____

CLINICAL INFORMATION

☐ E88.01 Alpha-1 antitrypsin deficiency ☐ Other ICD-10 code (Please Specify Diagnosis) : _____

Has the patient ever received augmentation therapy? ☐ Yes ☐ No If yes, which one: ☐ Aralast® ☐ Prolastin® ☐ Zemaira ☐ Glassia®

Does the patient have a smoking history: ☐ Yes ☐ No If yes, date stopped: _____ Vascular access: ☐ Peripheral ☐ Central ☐ Port

Please send the following clinical documentation:

☐ History and physical (signed) ☐ Serum AAT with genotype ☐ PFTs ☐ Lung imaging ☐ Non-smoker or smoking cessation program attestation

**Obtain the following labs at prior to start of treatment and at _____ frequency: ☐ CBC ☐ CMP ☐ CRP ☐ ESR ☐ LFTs ☐ X-Ray ☐ Other: _____

GLASSIA® ORDERS

Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____

Medication	Dose/Frequency	Refills
☐ Glassia® [Alpha1-Proteinase Inhibitor (Human)]	☐ Infuse 60mg per kg (+/– 10%) intravenously weekly (where clinically appropriate, round to the nearest vial size) ☐ Other: _____	_____

Pre-Medication	Dose/Strength	Directions
☐ Acetaminophen	☐ 500mg	☐ Take 1-2 tablets by mouth prior to infusion or post-infusion as directed
☐ Cetirizine	☐ 10mg	☐ Take 1 tablet by mouth prior to infusion or as directed
☐ Diphenhydramine	☐ 25mg IV/By mouth ☐ 50mg IV/By mouth	☐ Take 1 tablet by mouth prior to infusion or as directed OR Inject contents of 1 vial IV prior to infusion or as directed
☐ Methylprednisolone	☐ 40mg ☐ 100mg ☐ 125mg	☐ Inject contents of 1 vial IV prior to infusion or as directed ☐ Other: Inject 100mg IV 30 minutes prior to infusion
☐ _____	_____	_____

ANAPHYLACTIC REACTION (AR):

☐ EpiPen® Auto-injector 0.3 mg (1:1000) Inject IM -or- SubQ to patients who weigh ≥ 66 lbs (≥ 30 kg); may repeat in 3-5 mins x 1 if necessary

☐ EpiPen Jr® Auto-injector 0.15mg (1:2000) Inject IM -or- SubQ to patients who weigh 33 - 66 lbs (15-30 kg): may repeat in 3-5 mins x 1 if necessary

☐ Diphenhydramine 50mg (1mL) - Administer 50 mg VIA slow IVP, administer IM if no IV access; may repeat x 1 after 10 mins, if necessary

☐ Methylprednisolone 40mg - administer 40 mg IVP -or- IM if no IV access

☐ Sodium Chloride 0.9% 500 mL infuse IV at a rate of up to 999 mL/hr

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☐ Other: _____

SIGNATURE

We hereby authorize Valustar to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X_____ Date: _____

Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.