



PATIENT INFORMATION (Complete or Fax Existing Chart)		PRESCRIBER INFORMATION	
Name: _____ DOB: _____ Address: _____ City, State, Zip: _____ Phone: _____ Alt. Phone: _____ Email: _____ SS#: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____ Allergies: _____		Prescriber Name: _____ State License: _____ NPI #: _____ Tax ID: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ Office Contact: _____ Phone: _____	
<b>INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front &amp; back)</b>			
Primary Insurance: _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____		Secondary Insurance (If Applicable): _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____	
<b>CLINICAL INFORMATION</b>			
<input type="checkbox"/> E88.01 Alpha-1 antitrypsin deficiency <input type="checkbox"/> Other ICD-10 code (Please Specify Diagnosis) : _____ 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 <input type="checkbox"/> Glassia® Does the patient have a smoking history: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date stopped: _____ Vascular access: <input type="checkbox"/> Peripheral <input type="checkbox"/> Central <input type="checkbox"/> Port Please send the following clinical documentation: <input type="checkbox"/> History and physical (signed) <input type="checkbox"/> Serum AAT with genotype <input type="checkbox"/> PFTs <input type="checkbox"/> Lung imaging <input type="checkbox"/> Non-smoker or smoking cessation program attestation **Obtain the following labs at prior to start of treatment and at _____ frequency: <input type="checkbox"/> CBC <input type="checkbox"/> CMP <input type="checkbox"/> CRP <input type="checkbox"/> ESR <input type="checkbox"/> LFTs <input type="checkbox"/> X-Ray <input type="checkbox"/> Other: _____			
<b>GLASSIA® ORDERS</b>			
Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____			
<b>Medication</b>	<b>Dose/Frequency</b>		<b>Refills</b>
<input type="checkbox"/> Glassia® [Alpha1-Proteinase Inhibitor (Human)]	<input type="checkbox"/> Infuse 60mg per kg (+/- 10%) intravenously weekly (where clinically appropriate, round to the nearest vial size) <input type="checkbox"/> Other: _____		_____
<b>Pre-Medication</b>	<b>Dose/Strength</b>	<b>Directions</b>	
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> 500mg	<input type="checkbox"/> Take 1-2 tablets by mouth prior to infusion or post-infusion as directed	
<input type="checkbox"/> Cetirizine	<input type="checkbox"/> 10mg	<input type="checkbox"/> Take 1 tablet by mouth prior to infusion or as directed	
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> 25mg IV/By mouth <input type="checkbox"/> 50mg IV/By mouth	<input type="checkbox"/> Take 1 tablet by mouth prior to infusion or as directed OR Inject contents of 1 vial IV prior to infusion or as directed	
<input type="checkbox"/> Methylprednisolone	<input type="checkbox"/> 40mg <input type="checkbox"/> 100mg <input type="checkbox"/> 125mg	<input type="checkbox"/> Inject contents of 1 vial IV prior to infusion or as directed <input type="checkbox"/> Other: Inject 100mg IV 30 minutes prior to infusion	
<input type="checkbox"/> _____	_____	_____	
<b>ANAPHYLACTIC REACTION (AR):</b>			
<input type="checkbox"/> 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 <input type="checkbox"/> 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 <input type="checkbox"/> Diphenhydramine 50mg (1mL) - Administer 50 mg VIA slow IVP, administer IM if no IV access; may repeat x 1 after 10 mins, if necessary <input type="checkbox"/> Methylprednisolone 40mg - administer 40 mg IVP -or- IM if no IV access <input type="checkbox"/> Sodium Chloride 0.9% 500 mL infuse IV at a rate of up to 999 mL/hr			

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**GLASSIA®**

**Please Fax Completed Form To: 888-898-9113**

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

☐ 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 \_\_\_\_\_

Prescriber Signature

Date: \_\_\_\_\_

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.

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