CSI CLINICAL SPECIALTY INFUSIONS

Phone: 833-569-1005 | Fax: 430-200-4889 | Online: deliver.myforcura.com

ALPHA-1 PROTEINASE INHIBITOR ENROLLMENT FORM

Account manager: _____ Contact info: _____

✂ AZ: Please detach before submitting to a pharmacy.

PATIENT INFORMATION

Patient Name:		Caregiver (if applicable):	
Address:	City:	State:	Zip:
Main Phone:	Alternate Phone:	Email:	Last 4 of SSN (required):
Date of Birth:	☐ Male or ☐ Female	Height (required): _____☐ cm or ☐ inches	Weight (required): _____☐ lb or ☐ kg

CLINICAL INFORMATION

Primary ICD-10 Code:	Is patient currently on therapy? ☐ Yes or ☐ No	Previous tried/failed therapies:
Allergies:	Current medications:	

Please include face sheet, copy of insurance cards (front and back), H&P, clinicals and any available lab results.

PRESCRIPTION AND ORDERS

Medication	Dosing		Quantity	Refills
☐ **Alpha-1 Proteinase Inhibitor** (Aralast NP®, Glassia®, Zemaira®)	**First Dose:** ☐ Yes or No _____ ☐ If No, indicate when the next dose is needed and previous medication: Date Due: _____ Medication: _____	**Maintenance:** ☐ 60 mg/kg weekly (+/-15%) ☐ Other: _____ **Access:** ☐ Peripheral IV ☐ Port (may attempt PIV if unable to access PORT)	☐ 4-week supply ☐ Other: _____	x 1 year unless noted otherwise: ☐ ____refills

If specific Alpha-1 Proteinase Inhibitor product is desired enter brand here (otherwise Pharmacist will choose appropriate product for patient if left blank):

Medication Specific Infusion Rates:
Aralast NP® - Infuse over approximately 15 minutes at a rate not to exceed 0.2 mL/kg/min as tolerated by the patient.
Glassia® - Infuse over approximately 15 minutes at a rate not to exceed 0.2 mL/kg/min as tolerated by the patient.
Zemaira® - Infuse over approximately 15 minutes at a rate not to exceed 0.08 mL/kg/min as tolerated by the patient.

Labs:

Flush Orders: Flush with 0.9% sodium chloride 5-10 mL pre and post medication and as needed, max per dispense x 60 syringes (refill x 1 year). For CVADs ONLY, may add Heparin 3-5 mL as final flush to maintain patency as needed; PORT 100 units/mL; PICC 10 units/mL, max per dispense x 30 syringes (refill x 1 year).

Supplies: Dispense ancillary supplies as needed to provide home infusion therapy.

Premedication 30 minutes prior to infusion:
☐ Acetaminophen 325-650 mg PO, dispense x 1 bottle(refill x 1 year)
☐ Diphenhydramine 25 mg PO, dispense x 1 bottle(refill x 1 year)

Adverse/Anaphylactic Reactions, per protocol (Self administration):
- Epinephrine autoinjector 0.3 mg IM as directed PRN for anaphylaxis, dispense 2pk x 1 (refill x 1 year)

Adverse/Anaphylactic Reactions, per protocol (Nurse Administration): dispense ana-kit x 1 (refill x 1 year)
- Epinephrine 1:1000, 1 mL vial x 1
- Diphenhydramine 50 mg/1 mL vial x 1
- Diphenhydramine 50 mg tab/cap x 1
- 0.9% Sodium Chloride 500 mL bag x 1

Nursing Orders for Home Infusion: Provide skilled nursing for home medication administration as prescribed and per CSI nursing policies. Insert, access, and manage vascular access devices. Deliver nursing care for therapy duration and educate patient on medication, disease state, adverse reactions, and administration. Monitor patient response and report adverse events. Additional teaching visits may be required for self-administration.

PRESCRIBER INFORMATION

Prescriber Name:		Practice site name:	
Address:	City:	State:	Zip:
NPI:	Phone:	Fax:	

Office contact and special instructions:

Prescriber Authorization: I authorize the pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Prescriber's Signature: **Date:**