WELLPARTNER PHARMACY | ALPHA-1 PROTEINASE INHIBITOR DEFICIENCY ENROLLMENT FORM

Wellpartner

FAX FORM TO: 1.877.597.3070 | **PHONE:** 1.800.473.3516 | **EMAIL:** specialty@wellpartner.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION

Name:

Address:

City, State, ZIP:

Primary Phone: - - DOB: / /

Alternate Phone: - - Gender:

Email:

Primary Language: Last Four of SSN:

2. PRESCRIBER INFORMATION

Name:

DEA #: NPI #: State Lic. #:

Group or Hospital:

Address:

City, State, Zip:

Phone: - - Fax: - -

Contact Person: Phone: - -

3. INSURANCE INFORMATION

*Fax copy of **prescription** and **insurance cards** with this form, if available (front and back)*

Primary Insurance Company Name:

Primary Cardholder Name:

Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent

Phone: - - Member ID: Group #:

Secondary Insurance Company Name:

Secondary Cardholder Name:

Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent

Phone: - - Member ID: Group #:

4. DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: / / Ship to: ◯ Patient ◯ Office ◯ Other:

Date of Diagnosis: / /

◯ E88.Ø1 Alpha1-antitrypsin deficiency (congenital emphysema)

◯ Other:

Height (in/cm): Weight (lb/kg):

Allergies:

Concomitant Medications:

Is patient currently on AAT treatment? ◯ Yes ◯ No If no, what is serum AAT level? _____ µM

What is the post-bronchodilation FEV1?

Has hepatitis B risk been evaluated or vaccination initiated? ◯ Yes ◯ No

Does the patient have selective IgA deficiency with known antibody against IgA? ◯ Yes ◯ No

Specialty pharmacy to coordinate home health nursing visit as necessary ◯ Yes ◯ No

◯ Home health nursing visit coordination is not necessary

Reason: ◯ MD office to administer to patient

◯ Home health nursing already coordinated

5. PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
◯ Aralast™	◯ 150 mg vial kit ◯ 1.0 g vial kit	◯ Administer 60 mg/kg via intravenous infusion once weekly. ◯ Administer _____ mg/kg via intravenous infusion once weekly.	◯ 4-week supply ◯ 12-week supply	
◯ Glassia™	1 gm/50 ml	Administer 60 mg/kg via intravenous infusion once weekly.	◯ 4-week supply ◯ 12-week supply	
◯ EpiPen®	0.3 mg autoinjector	Use as directed.	2-pack kit	PRN
◯ Zemaira®	_____ mg	Administer 60 mg/kg via intravenous infusion once weekly.	◯ 4-week supply ◯ 12-week supply	
◯				
◯				

Vascular access method: ◯ Peripheral ◯ Central ◯ Other: _____

Flushing protocol (please describe):

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE

X / /

DISPENSE AS WRITTEN DATE

X / /

PRODUCT SUBSTITUTION PERMITTED DATE