Alpha-1 Antitrypsin Deficiency

225 Route 46 West Suite 3
Totowa, NJ 07512
Phone: 973-837-6877
Fax: 973-837-6878

patient information

patient: ______________________________ male female DOB: __________ SS#: __________
last name, first name mm/dd/yyyy

address: ______________________________
street city state zip

primary phone number: __________ cell alternate phone number: __________ cell

insurance information (Please provide a copy of the front and back of the insurance card or complete the fields below.)

Primary insurance: __________ Phone: __________

Subscriber name: __________ DOB: __________

Employer: __________ Group/policy #: __________ ID #: __________

Secondary insurance: __________ Phone: __________

Subscriber name: __________ DOB: __________

Employer: __________ Group/policy #: __________ ID #: __________

Check here if physician would like to be contacted with insurance information prior to pharmacy contacting the patient.

medical history

diagnosis related to infusion therapy **description: Alpha-1 Antitrypsin Deficiency** ICD-10: E88.01

Coronary artery disease Smoker Overweight Renal disease IgA deficiency Previous MI, DVT, TIA COPD Liver disease
Hypertension Diabetes Asthma Other:__________

If previous smoker, date stopped:__________ Allergies:__________ Weight:__________ lb kg Height:__________ in cm

Serum AAT level:__________ mg/dl or __________uM Date:__________ PFT: FEV$_1$ % predicted:__________

CXR/CT results:__________ Phenotype: PiZZ PiSZ PiMZ Other: __________

prescription	dose	directions	quantity	**refills**
Glassia ™ Zemaira® Aralast NP ™	60 mg/kg weekly Other:__________ __________	Infuse per manufacturer's guidelines Other:__________ __________	1-month supply (unless otherwise directed) Other:__________ __________	1 year (unless otherwise directed) Other:__________ __________
Anaphylaxis kit		Use as directed for anaphylaxis		

Venous access IV administration type: PICC Tunneled central venous line Port RN to place peripheral IV as needed for therapy

Flush orders: __________

Additional orders: __________

prescriber + shipping information

prescriber (print): __________ office contact: __________

preferred method of contact: phone fax email preferred contact persons email: __________

ship to: patient office alternate __________
shipping adddress: street city state zip

office address: __________
(street, suite, city, state, zip)

phone: __________ fax: __________ N PI: __________ DEA: __________

prescriber's signature: __________ date: __________

insurance information: please fax copy of insurance card (front + back)