

Alpha-1 Antitrypsin Deficiency Physician Referral Form

Fax to: 866.739.2316 **Date:** _____

Patient Name _____ SS# _____ - _____ - _____
 DOB _____ / _____ / _____ Sex M F Phone _____
 Address _____
 City _____ State _____ Zip _____

Insurance Primary _____ Phone _____
Attach copy of card if available Subscriber Name _____ DOB _____
 ID# _____ Policy/Group # _____
 Secondary _____ Phone _____
 Subscriber Name _____ DOB _____
 ID# _____ Policy/Group # _____
 Check here if physician would like to be contacted with insurance information prior to contacting the patient.

Physician Name _____ Phone _____ Fax _____
 Address _____
 City _____ State _____ Zip _____
 DEA# _____ License # _____ Provider # _____
 Office Contact _____ Phone (if different) _____

Diagnosis Primary Alpha-1 antitrypsin deficiency ICD-9 273.4
 Secondary _____ ICD-9 _____
 Medical History Asthma Allergies COPD Smoking History
 Underweight Overweight Liver Disease Renal Disease Diabetes

Therapy Drug Name Zemaira® [alpha-1 proteinase inhibitor (Human)]
 Patient Wt. _____ kg (1kg = 2.2 lb) Dose* _____ mgs Frequency* Weekly Other _____
** The recommended dose for Zemaira is 60 mg/kg of body weight, administered once weekly. Actual dose may vary by up to 10% (plus or minus) based on available assay size from the drug manufacturer.*

Additional Orders/Information (including lab orders, access device, supplies and nursing)

Pre-medication:
 Patient may be taught to self-infuse: Yes No Administration supplies as required? Yes No

I certify that the prescribed therapy is medically necessary for the treatment of alpha-1-antitrypsin deficiency and that the above information is accurate to the best of my knowledge and belief. The patient is under my care and is in need of the services indicated.

Physician's Signature: _____ **Date/Time:** _____

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