Alpha-1 Antitrypsin Deficiency

DIPLOMAT®

Specialty Infusion Group

toll-free phone **866.500.6500**
toll-free fax **855.817.2618**
1370 Busch Parkway
Buffalo Grove, IL 60089

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: _____ NPI: _____ DEA: _____

prescriber's signature: _____ date: _____

I authorize Diplomat Pharmacy, Inc. and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Diplomat Pharmacy, Inc

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