

Pharmacy Name: _____ Phone: _____
 Address: _____ Fax: _____
 City/State/Zip: _____ Email: _____

Alpha1 Therapy Referral Form

Patient Information PLEASE FAX INSURANCE CARD (FRONT AND BACK)

Prescriber Information

Last Name	First Name	DOB	Practice/Facility Name
Address	Address		
City State Zip	City State Zip		
Phone SSN	Prescriber Name		
Allergies Latex Allergy	Prescriber NPI		
Sex M F Weight (kg) Height (ft,in)	Nurse/Key Contact		
Insurance Plan	Phone/Pager		
Plan ID #	Fax	Email	

Prescription Information

Medication	Dose and Directions	Quantity	Refills
Glassia®	60mg/kg via IV infusion once every week <input type="checkbox"/> other _____ mg/kg via IV infusion once every week <input type="checkbox"/> other	<input type="checkbox"/> 4 week supply <input type="checkbox"/> 12 week supply	<input type="checkbox"/> 1 year
Aralast®	60mg/kg via IV infusion once every week <input type="checkbox"/> other _____ mg/kg via IV infusion once every week <input type="checkbox"/> other	<input type="checkbox"/> 4 week supply <input type="checkbox"/> 12 week supply	<input type="checkbox"/> 1 year
Prolastin-C®	60mg/kg via IV infusion once every week <input type="checkbox"/> other _____ mg/kg via IV infusion once every week <input type="checkbox"/> other	<input type="checkbox"/> 4 week supply <input type="checkbox"/> 12 week supply	<input type="checkbox"/> 1 year
Epinephrine® <input type="checkbox"/> IM <input type="checkbox"/> SQ	Adult 1:1000, 0.3mL (>30kg/>66lbs) Peds 1:2000, 0.3mL (15-30kg/33-66lbs) PRN Anaphylaxis Repeating Dose:	<input type="checkbox"/> Once	<input type="checkbox"/> 1 year
Normal Saline D5W	<input type="checkbox"/> 3mL <input type="checkbox"/> 5mL Other: _____ IV before and after infusion	<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months	<input type="checkbox"/> 1 year
Heparin 10 units/mL Heparin 100 units/mL	<input type="checkbox"/> 3mL <input type="checkbox"/> 5mL Other: _____ IV before and after infusion	<input type="checkbox"/> 1 month <input type="checkbox"/> 3 months	<input type="checkbox"/> 1 year

Other: _____

Vascular Access Method: <input type="checkbox"/> Peripheral <input type="checkbox"/> Central <input type="checkbox"/> Other: <input type="checkbox"/> Ship to Patient <input type="checkbox"/> Office Other:	Diagnosis and Clinical Information Diagnosis (ICD-10): <input type="checkbox"/> E88.01 (Congenital Emphysema) Alpha1-Antitrypsin Deficiency Other Code: Description: Diagnosis (ICD-10): Allergies:
---	--

FEV1: _____ % predicted

Serum A1AT levels (pretreatment) _____ md/dl or microM

Does the patient display clinically evident emphysema? Yes No

Needs by Date: _____

Lab Orders: _____

Nursing: Please arrange nursing administration Patient may be taught to self-infuse

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitution:

I authorize Fannin Infusion Pharmacy and its representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Fannin Infusion Pharmacy.

Physician Signature: _____
Date: _____

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED

The attached document(s) contain confidential information which may be considered to be Protected Health Information and therefore required to be maintained as private and secure under HIPAA. The documents may also contain information which is otherwise considered to be privileged under state and federal laws. This communication is for the intended recipient only. If you are not the intended recipient, or a person responsible for delivering this communication to the intended recipient, you are prohibited from viewing, copying and/or distributing the information contained herein. Unlawful disclosure of the information attached may subject you to monetary penalties and sanctions. If you have received this communication in error, you should notify the sender immediately and thereafter permanently destroy all copies of this document in its entirety.

This form is not considered an order or prescription for medical services and/or supplies unless and until it is formally authorized by a healthcare provider in compliance with applicable laws and regulations.

This is not a valid prescription in the state of Arizona.

© 2026 Fannin Infusion Pharmacy | VC44007-1224