Alpha-1 Augmentation Order Form

Pre-filled order form for Alpha-1 Augmentation (alpha-1 proteinase inhibitor) — Weekly IV replacement therapy for alpha-1 antitrypsin deficiency

REFERRING PROVIDER

PROVIDER NAME | NPI | DEA (IF CONTROLLED) | SPECIALTY

PRACTICE / CLINIC NAME | OFFICE PHONE | OFFICE FAX

OFFICE CONTACT NAME | CONTACT PHONE | CONTACT EMAIL

PATIENT INFORMATION

PATIENT LAST NAME | FIRST NAME | MIDDLE INITIAL

DATE OF BIRTH | SEX | PATIENT PHONE | BEST TIME TO CONTACT

ADDRESS | CITY, STATE, ZIP

INSURANCE

PRIMARY INSURANCE | MEMBER ID | GROUP #

SECONDARY INSURANCE (IF ANY) | MEMBER ID | GROUP #

DIAGNOSIS & CLINICAL JUSTIFICATION

PRIMARY DIAGNOSIS | ICD-10 CODE

SECONDARY DIAGNOSIS (IF APPLICABLE) | ICD-10 CODE

Common indications for this medication: *Alpha-1 antitrypsin deficiency (genetic), Alpha-1 related emphysema and chronic obstructive pulmonary disease, Slowing the progression of lung tissue damage in deficient patients*

BRIEF CLINICAL SUMMARY / JUSTIFICATION FOR THERAPY

PRIOR THERAPIES TRIED AND OUTCOME

ALPHA-1 AUGMENTATION REFERENCE

Generic name:	alpha-1 proteinase inhibitor
Specialty:	Pulmonology
Typical infusion time:	30–60 minutes
Typical schedule:	Once weekly, lifelong
Biosimilars / brands:	Aralast NP, Prolastin-C, Glassia (interchangeable products)

MEDICATION ORDER

MEDICATION (DEFAULT: ALPHA-1 AUGMENTATION)

GENERIC / ALT (ALPHA-1 PROTEINASE INHIBITOR)

STRENGTH / FORMULATION

DOSE

FREQUENCY (TYPICAL: ONCE WEEKLY, LIFELONG)

DURATION (TYPICAL: 30&NDASH;60 MINUTES)

ROUTE

PRE-MEDICATIONS (IF ANY)

SPECIAL INSTRUCTIONS

ANTICIPATED START DATE

 # OF DOSES AUTHORIZED

SUBSTITUTION ALLOWED (Y/N)

BIOSIMILAR ACCEPTABLE (Y/N)

REQUIRED LABS & MONITORING

Check all labs the prescriber requires Ascribe to verify before each infusion:

- ☐ CBC w/ differential
- ☐ CMP
- ☐ Liver function panel
- ☐ Hepatitis B/C panel
- ☐ TB screen (T-SPOT or QFT)
- ☐ Pregnancy test (urine)
- ☐ Iron studies (ferritin, TSAT)
- ☐ Vitamin levels (B12, D, folate)
- ☐ Other (specify below)

OTHER LABS / MONITORING REQUIREMENTS

PRESCRIBER SIGNATURE

By signing below I certify that this order is medically necessary, that I am the prescribing provider for this patient, and that I have reviewed the patient's clinical history relevant to this therapy. Ascribe Infusion Therapy is authorized to coordinate scheduling, prior authorization, and benefits verification on the patient's behalf.

PRESCRIBER SIGNATURE	PRINTED NAME	DATE

Form code: ARB-ORDER-ALPHA-1-AUGMENTATION · Submit to Ascribe Infusion Therapy by fax to [FAX NUMBER] or via secure portal. Ascribe Infusion will confirm receipt within one business day and begin prior authorization the same day. Questions: [PHONE] · hello@ascribeinfusion.com