BioPlus® Infusion | Santa Barbara Pharmacy

Skip this form & e-prescribe! Select BioPlus from your EHR!

ALPHA-1 ANTITRYPSIN DEFICIENCY

Fax: 866-523-5406
Phone: 800-829-3975
bioplusinfusion.com

Ship To: ☐ **In Office** ☐ **Infusion Suite** ☐ **At Home** ☐ **Other**_____

PATIENT INFORMATION

Name:		SSN:		DOB:	
Address:		City:	State:	ZIP:	
Home Phone:	Cell:	Height:	Weight:	Gender: ○ Female ○ Male	
Email:		Allergies:			

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance Co:	Policy Holder:	Relationship:	Policy #:	Group #:
Secondary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:

CLINICAL INFORMATION (Fax all pertinent clinical and lab information)

Primary Diagnosis: E88.01 Alpha-1 antitrypsin deficiency **ICD-10:** E88.01 _____

Secondary Diagnosis: _____ **ICD-10:** E88.01 _____

Allergies: ☐ NKDA ☐ Other_____ **Clinically Evident Emphysema:** ☐Yes ☐ No

FEV1:_____ **Serum A1AT levels (pretreatment)**:_____mg/dL or _____micro M

First time receiving Alpha 1 therapy? ☐ Yes ☐ No If No, previous product used: _____ Last dose given: _____ Next dose due: _____

Lab orders: _____

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

MEDICATION	DIRECTIONS	QUANITY	REFILLS
ARALAST	☐ Infuse 60 mg per kg (+/– 10%) intravenously weekly where clinically appropriate, round to the nearest vial size ☐ Other _____	☐ 4 week supply ☐ 12 week supply	☐ 1 year ☐ Other
GLASSIA	☐ Infuse 60 mg per kg (+/– 10%) intravenously weekly where clinically appropriate, round to the nearest vial size ☐ Other _____	☐ 4 week supply ☐ 12 week supply	☐ 1 year ☐ Other

Pre-Medication

Diphenhydramine

☐ 25 mg capsule: 1-2 capsules PO 15-30 minutes before each infusion ☐Decline

☐ Other_____ Strength:_____

Directions: _____

☐ Other_____ Strength:_____

Directions: _____

Vascular Access Device:

☐ Peripheral Catheter ☐ PICC ☐ Port

☐ Other (describe # of lumens): _____

Flush Orders: (If IV ordered the following flush protocols will be followed)

☐ **Sodium Chloride 0.9%**

Peripheral Line: 3 mL before each dose and 3 mL after each dose and PRN

Central Line: 5-10 mL before each dose and 5-10 mL after each dose and PRN

☐ **Heparin 10 u/mL** Peripheral Line: 3 mL after last sodium flush and PRN

☐ **Heparin 100 u/mL** Central Line: 5 mL after last sodium flush and PRN

Provide needles, syringes, VAD supplies & other ancillary supplies needed for infusion

Anaphylaxis Kit Order (Infusion Reaction Management x1/year)

☐ Epinephrine ☐ IM ☐ SUBQ Qty: _____ Refills: _____

Adult 1:1000, 0.3 mL (>30 kg/>66lbs) PRN severe allergic reaction - Call 911, May repeat in 5-15 minutes as needed.

As required by your state, Prescriberto check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. ☐ Dispense as written

NURSING

☐ **Nursing Agency:** _____ **Phone:** _____

Skilled Nursing Visits for Immune Globulin Intravenous administration and education. To provide education related to the disease process and IG therapy.
To provide an assessment of patient's general overall health status. To provide skilled nursing visits PRN for additional education and support.

PHYSICIAN INFORMATION — Injection Training: □ Office to Instruct □ SP to Arrange Teaching

Prescriber Name:	Phone:	Fax:	
Office Contact:		Email:	
Address:	City:	State:	ZIP:
NPI #:		Tax ID:	
Prescriber Signature:		Date:	