



PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ Tax ID: _____
Phone: _____ Alt. Phone: _____	Address: _____
Email: _____ SS#: _____	City, State, Zip: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	Office Contact: _____ Phone: _____

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____	Secondary Insurance (If Applicable): _____
Plan #: _____	Plan #: _____
Group #: _____	Group #: _____
RX Card (PBM): _____	RX Card (PBM): _____
BIN: _____ PCN: _____	BIN: _____ PCN: _____

CLINICAL INFORMATION

E88.01 Alpha-1 antitrypsin deficiency Other ICD-10 code (Please Specify Diagnosis) : _____

Has the patient ever received augmentation therapy? Yes No If yes, which one: Aralast® Prolastin® Zemaira Glassia®

Does the patient have a smoking history: Yes No If yes, date stopped: _____ Vascular access: Peripheral Central Port

Please send the following clinical documentation:

History and physical (signed) Serum AAT with genotype PFTs Lung imaging Non-smoker or smoking cessation program attestation

GLASSIA® ORDERS

Prescription type: New start Restart Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____

Medication	Dose/Frequency	Refills
<input type="checkbox"/> Glassia® [Alpha1-Proteinase Inhibitor (Human)]	<input type="checkbox"/> Infuse 60mg per kg (+/- 10%) intravenously weekly (where clinically appropriate, round to the nearest vial size) <input type="checkbox"/> Other: _____	_____
Pre-Medication	Dose/Strength	Directions
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> 500mg	<input type="checkbox"/> Take 1-2 tablets PO prior to infusion or post-infusion as directed
<input type="checkbox"/> Cetirizine	<input type="checkbox"/> 10mg	<input type="checkbox"/> Take 1 tablet PO prior to infusion or as directed
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> 25mg IV/PO <input type="checkbox"/> 50mg IV/PO	<input type="checkbox"/> Take 1 tablet PO prior to infusion or as directed OR Inject contents of 1 vial IV prior to infusion or as directed
<input type="checkbox"/> Methylprednisolone	<input type="checkbox"/> 40mg <input type="checkbox"/> 100mg <input type="checkbox"/> 125mg	<input type="checkbox"/> Inject contents of 1 vial IV prior to infusion or as directed <input type="checkbox"/> Other: Inject 100mg IV 30 minutes prior to infusion
<input type="checkbox"/> _____	_____	_____

SIGNATURE

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X _____ Date: _____

Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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