vitalcare INFUSION SERVICES

Pharmacy Name: Vital Care of Tampa
Address: 8600 Hidden River Parkway, Ste 300
City/State/Zip: Tampa, FL 33637

Phone: 813-632-8545
Fax: 813-522-8660
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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 Y N		Prescriber NPI		
Sex M F	Weight (kg)	Height (ft,in)	Nurse/Key Contact		
Insurance Plan			Phone/Pager		
Plan ID #			Fax	Email	

Diagnosis and Clinical Information

Diagnosis (ICD-10):
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? Y N

Needs by Date: Ship to Patient Office Other:
Lab Orders:
Nursing: Please arrange nursing administration
Patient may be taught to self-infuse

Prescription Information

Medication	Dose and Directions		Quantity	Refills
Glassia®	via IV infusion every			1 year
Aralast®	via IV infusion every			1 year
Prolastin-C®	via IV infusion every			1 year
Epinephrine Epipen or ampule	Adult 1:1000, 0.3mL (>30kg/>66lbs) Peds 1:2000, 0.3mL (15-30kg/33-66lbs)	PRN Anaphylaxis	Once	1 year
Normal Saline Heparin 100 units/mL	5-10mL of Sodium Chloride 0.9% 3-5mL via SASH method (central lines only)	IV before and after infusion via SASH method	PRN	1 year
Lidocaine/Prilocaine 2.5%-2.5% Cream	Apply to affected area	As needed prior to needle insertion for catheter related discomfort	PRN	1 year
☐ Other:				
☐ Vascular Access Method:	Peripheral Central Other:			

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 Vital Care Infusion Services LLC 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 Vital Care.

Physician Signature: ____________________

Date: ____________________

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

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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.