PROLASTIN-C LIQUID Enrollment Form with Quick Start

Fax completed form to: 1-888-817-2098

PROLASTIN DIRECT® Your partner in alpha-1

Accredo By EVERNORTH

READY-TO-INFUSE PROLASTIN® C LIQUID alpha1-proteinase inhibitor (human)

PATIENT INFORMATION

First name _____ Middle initial ____ Last name _____ SSN (last 4 digits only) _____ DOB ___/___/___ Gender ☐ M ☐ F

Home address _____ City _____ State _____ Zip _____

Best contact number _____ ☐ Home ☐ Mobile ☐ Work Email address _____

Please attach copies of the front and back of the patient's medical and prescription insurance cards.

MEDICAL INFORMATION *Please include a copy of patient's clinical notes*

ICD-10 Diagnosis ☐ Alpha$_1$-Antitrypsin Deficiency E88.01 ☐ Panlobular Emphysema J43.1 ☐ Other _____

AAT Phenotype/Genotype ☐ PiZZ ☐ PiZ (null) ☐ Pi (null, null) ☐ PiSZ ☐ Other _____ FEV$_1$ _____ % predicted DLCO _____ % predicted

Serum AAT Level _____ mg/dL or _____ µM Allergies ☐ None or ☐ Specify _____

Treatment History Has patient ever received augmentation therapy? ☐ Yes ☐ No If yes, which therapy? _____

Medical History ☐ COPD ☐ Asthma ☐ Emphysema ☐ Other _____

Concurrent medications _____ Vascular access ☐ Peripheral ☐ Central ☐ Port

Smoking History ☐ Yes ☐ No

If yes, date stopped. ___/____

PROLASTIN-C LIQUID PRESCRIPTION INFORMATION

Dose

☐ 60 mg/kg (+/- 10%) IV once weekly

☐ Other dose/frequency _____

Patient weight _____ lbs / kg recorded on ___/___/___

Directions

Rate: As tolerated by patient up to 0.08 mL/kg/min

☐ Other rate _____

Quantity/Refills

☐ Dispense up to 28-day supply. Refill x1 year unless otherwise noted

☐ Other _____

Medications to be used as needed:

☐ Lidocaine 4% applied topically to insertion site prior to needle insertion as needed for intravenous site pain

☐ Premedication/other orders: _____

Adverse reaction medications: *(keep on hand at all times)*

Epinephrine 0.3 mg auto-injector 2-pk for patients weighing greater than or equal to 30 kg. Administer intramuscularly as needed for severe anaphylactic reaction; may repeat one time.

Epinephrine 0.15 mg auto-injector 2-pk for patients weighing less than 30 kg. Administer intramuscularly as needed for severe anaphylactic reaction; may repeat one time.

Diphenhydramine 25 mg by mouth for mild allergic reactions and 50 mg for moderate-severe.

Flush orders:

Saline flushing

Normal saline 3 mL intravenous (peripheral line) or 10 mL intravenous (central line) before and after infusion, or as needed for line patency

Heparin flushing

Heparin 10 units per mL 3 mL intravenous (peripheral line) as final flush

Heparin 100 units per mL 5 mL intravenous (central line) as final flush

First infusion location preference: ☐ Home or ☐ Medical facility (name, phone of preferred facility, if any): _____

First infusion in home nursing orders:

Establish primary IV line with 250 to 500 mL of normal saline or ☐ Other _____ at KVO rate prior to infusion

Monitor patient including VS before, Q15 during, and 30 minutes post infusion

Skilled nursing visit as needed to establish venous access, administer medication and assess general status and response to therapy

Provide infusion supplies, including syringes and needles, to safely administer prescribed medication.

PRESCRIBER INFORMATION

Prescriber first name _____ Prescriber last name _____ NPI# _____

Street address _____ City _____ State _____ Zip _____

Office contact name _____ Office contact phone _____ Office contact fax _____

Office contact email address _____

By signing below, I authorize this prescription and certify that the therapy described above is medically necessary and that the information provided is accurate to the best of my knowledge. I authorize PROLASTIN DIRECT to act on my behalf for the limited purpose of transmitting this prescription by any means allowed under applicable law to Accredo Health Group, Inc. If the patient is 18 years old or younger, I attest that I have obtained permission from the patient's legal guardian.

Prescriber Signature _____ _____ Date _____

Dispense as Written *Substitution Permitted*

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

ENROLL PATIENT IN QUICK START PROGRAM

The PROLASTIN-C LIQUID Quick Start Program provides eligible patients new to PROLASTIN-C LIQUID with up to eight (8) weeks of no-cost therapy during the commercial insurance approval process. Eligible patients must have a confirmed alpha$_1$-antitrypsin deficiency diagnosis and valid PROLASTIN-C LIQUID prescription. The patient must also be new to PROLASTIN-C LIQUID.

See additional eligibility requirements on the next page

☐ **Yes Enroll my patient in the Quick Start Program**

Eligible patients can receive an initial fourteen (14) day supply. Patients continuing to seek or appeal coverage determination from their commercial insurer are eligible to receive up to a maximum of eight (8) weeks of PROLASTIN-C LIQUID dispensed in a two (2)-week supply EVERY fourteen (14) days.

To reach the PROLASTIN DIRECT care team, call 1-833-746-6321. Hours of Operation: 8 AM to 8 PM EST.

Please see Important Safety Information on the next page and accompanying full Prescribing Information for PROLASTIN-C LIQUID.

Fax completed form and documentation to 1-888-817-2098.
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Steps to e-Prescribe PROLASTIN-C LIQUID	1. Fax in the PROLASTIN-C LIQUID prescription and enrollment form 2. Prescribe PROLASTIN-C LIQUID 3. Choose Accredo Health Group, Inc. as the dispensing pharmacy	**eRx to NCPDP ID 4436920** 1620 Century Center Parkway, Suite 109, Memphis, TN 38134

PRIOR AUTHORIZATION CHECKLIST

Please note that the information listed below outlines what is typically required for insurance to review the patient's eligibility. If any of the following information is not provided, it may delay approval or be cause for a denial.

NEW DIAGNOSIS OF AATD

Required documentation for insurance review

(A) Laboratory work

- ☐ AAT serum concentration; Most major insurance policies define acceptable levels as: ≤11 µM (11 µmol/L) or 80 mg/dL by radial immunodiffusion or <50 mg/dL if measured by nephelometry
- ☐ Phenotype or Genotype: PiZZ, PiZ (null), Pi (null, null), PiSZ or other, in which case a one-on-one discussion may be required with the insurance plan medical director

(B) Most recent clinical and diagnostic test results documenting history of Emphysema

- ☐ Patient's medical records demonstrating diagnosis of AATD and clinical evidence of emphysema/worsening of emphysema due to lung disease exacerbations
- ☐ Diagnostic imaging-chest X-ray, CT scan
- ☐ Evidence of lung function decline, forced expiratory volume (FEV), and pulmonary function test (PFT)
- ☐ Patient's clinical notes and smoking history

Supplemental documentation that may be required by the insurance plan for approval

- ☐ Letter of medical necessity
- ☐ Peer-reviewed articles supporting diagnosis and treatment
- ☐ IgA antibody results (may be required for certain insurance plan approvals)

QUICK START ADDITIONAL ELIGIBILITY REQUIREMENTS

- Patients must meet all clinical criteria outlined in their commercial insurance plan's medical policy
- The patient must experience a delay of five (5) business days or more in securing a benefits investigation or prior authorization for PROLASTIN-C LIQUID
- This program is not valid for prescriptions reimbursed, in whole or in part, by Medicaid, Medicare, Medigap, VA, DoD, TRICARE, or any other federal or state healthcare programs
- Patients must have commercial insurance that covers medication costs for PROLASTIN-C LIQUID treatment
- This program is only valid for residents of the United States, including the District of Columbia, Puerto Rico, and other US territories

IMPORTANT SAFETY INFORMATION

PROLASTIN®-C LIQUID is an alpha$_1$-proteinase inhibitor (human) (alpha$_1$-PI) indicated for chronic augmentation and maintenance therapy in adults with clinical evidence of emphysema due to severe hereditary deficiency of alpha$_1$-PI (alpha$_1$-antitrypsin deficiency).

Limitations of Use

- The effect of augmentation therapy with any alpha$_1$-PI, including PROLASTIN-C LIQUID, on pulmonary exacerbations and on the progression of emphysema in alpha$_1$-PI deficiency has not been conclusively demonstrated in randomized, controlled clinical trials
- Clinical data demonstrating the long-term effects of chronic augmentation or maintenance therapy with PROLASTIN-C LIQUID are not available
- PROLASTIN-C LIQUID is not indicated as therapy for lung disease in patients in whom severe alpha$_1$-PI deficiency has not been established

PROLASTIN-C LIQUID is contraindicated in immunoglobulin A (IgA)-deficient patients with antibodies against IgA or patients with a history of anaphylaxis or other severe systemic reaction to alpha$_1$-PI products.

Hypersensitivity reactions, including anaphylaxis, may occur. Monitor vital signs and observe the patient carefully throughout the infusion. If hypersensitivity symptoms occur, promptly stop PROLASTIN-C LIQUID infusion and begin appropriate therapy.

Because PROLASTIN-C LIQUID is made from human plasma, it may carry a risk of transmitting infectious agents, eg,viruses, the variant Creutzfeldt-Jakob disease (vCJD) agent, and, theoretically, the Creutzfeldt-Jakob disease (CJD) agent. This also applies to unknown or emerging viruses and other pathogens.

The most common adverse reactions during PROLASTIN-C LIQUID clinical trials in >5% of subjects were diarrhea and fatigue, each of which occurred in 2 subjects (6%).

Please see accompanying full Prescribing Information for PROLASTIN-C LIQUID.

Sample PROLASTIN-C LIQUID Prescription and Enrollment Form

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Home address _____ City _____ State _____ Zip _____

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Smoking History ☐Yes ☐No

If yes, date stopped. ___/____

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Dose	Directions	Quantity/Refills
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INSURANCE CARDS 1

Attach a copy of the front and back of the patient's medical and prescription card(s) to assist with verifying plan/benefit eligibility.

ICD-10 DIAGNOSIS 2

These are common ICD-10 diagnosis codes for alpha-1. All appropriate codes should be selected/written in.

PHENOTYPE/GENOTYPE 3

The appropriate phenotype/genotype box must be selected/written in.

SMOKING HISTORY 4

Smoking history is required for many insurance plans.

FIRST DOSE LOCATION PREFERENCE(S) 5

Check either home or medical facility for first infusion location preference. Check both if there is no preference.

OFFICE CONTACT INFO 6

Please provide the best contact name and information of a representative from your office. This will facilitate communication between Accredo and the prescribing office.

QUICK START PROGRAM ENROLLMENT 7

Check this box to enroll a patient in the PROLASTIN-C LIQUID Quick Start Program.

DISPENSE AS WRITTEN (DAW) 8

To honor your request for PROLASTIN-C LIQUID, please sign on the DAW line.

Please see Important Safety Information on the next page and accompanying full Prescribing Information for PROLASTIN-C LIQUID.

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PROLASTIN DIRECT® CONTACT INFORMATION 9

Be sure to fax completed forms and documentation to the PROLASTIN DIRECT® team at Accredo.

STEPS TO E-PRESCRIBE 10

Always choose Accredo as the dispensing pharmacy.

DOCUMENTATION 11

Submit all required documentation listed under (A) Laboratory work and (B) Most recent clinical and diagnostic results. Including all documents at the time of referral submission may help avoid delays in the insurance prior authorization process.

ADDITIONAL DOCUMENTATION 12

The supplemental list of documentation may be required by certain health plans as additional supportive documentation.

QUICK START ELIGIBILITY REQUIREMENTS 13

Please review the list of eligibility requirements for the Quick Start Program.

To help minimize delays in processing approvals, please fill out this form completely and submit all required documentation.

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 March 2024 US-PRL-2400017