Local Infusion

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ALPHA1-PROTEINASE INHIBITOR (HUMAN) ORDER FORM

❑ Aralast ❑ Glassia ❑ Prolastin-C Liquid ❑ Zemaira

❑ **OK to change to a suggested biosimilar above based on insurance or availability**

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____

Allergies: _____

DIAGNOSIS (Provider must specify)

❑ Emphysema due to severe hereditary deficiency of Alpha1-PI (alpha1-antitrypsin deficiency), ICD 10: E88.01

❑ Other: _____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI: _____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (Not typically indicated)

❑ Acetaminophen (Tylenol) 500 mg PO ❑ Famotidine 20 mg IV ❑ Methylprednisolone (Solu-Medrol) 125 mg IVP

❑ Benadryl 25mg PO ❑ Cetirizine (Zyrtec) 10 mg PO

❑ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Alpha1-Proteinase Inhibitor (Human)	❑ 60 mg/kg body weight intravenously once per week	❑ IV	❑ once per week

❑ New Start Therapy ❑ Continuation of Therapy Date of last dose (if applicable): _____

LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS: ❒ CT: 203.433.0621 ❒ ME: 207.407.7272 ❒ NH: 603.217.5371 ❒ NJ: 201.581.4521

Order valid for 1 year from date of signature unless otherwise specified here: _____