ALPHA-1 ANTITRYPSIN THERAPY

(Including Prolastin and Glassia)

FAX to + 1 208.963.3245 or
Email to intake@infusionspecialists.org
To ensure processing of your order, please complete all fields.

INFUSION SPECIALISTS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- Hep B Panel
- IG Panel
- Most Recent FEV1
- AAT Level and Phenotype/Genotype
- For Prolastin referrals: Completed Prolastin Direct enrollment form

PRIMARY DIAGNOSIS

☐ E88.01 Alpha-1 antitrypsin deficiency
☐ J43.1 Panlobular emphysema
☐ J43.2 Centrilobular emphysema
☐ J43.8 Other emphysema
☐ Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Prolastin or Glassia
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

☐ Prolastin-C 60mg/kg (+/-10%) IV weekly
☐ Glassia 60mg/kg (+/-10%) IV weekly
☐ Other: _____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Infusion Specialists' protocol (See infusionspecialist.org for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Infusion Specialists' protocol (See infusionspecialist.org for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ _____
Provider Signature Date