

Alpha1 Proteinase Inhibitor, Human (Aralast NP)

Provider Order Form rev. 12/01/2021



PATIENT INFORMATION

Patient Name: _____ DOB: _____

NKDA Allergies: _____ Weight lbs/kg: _____

Patient Status: New to Therapy Continuing Therapy Next Due Date (if applicable): _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

ICD-10 CODE

- E88.01 Alpha 1 proteinase inhibitor deficiency
- Other: _____

MEDICATION ORDER

Dose: 60 mg/kg Other: _____

Frequency: IV weekly
other: _____

Rate: Administer at a rate not to exceed 0.2mL/kg/min
Other: _____

- Flush with 0.9% sodium chloride at the completion of infusion

SPECIAL INSTRUCTIONS

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions.

Provider Name (Print) _____ Provider Signature _____ Date _____

REQUIRED DOCUMENTATION

- Recent Office notes (along with any therapies tried and outcomes)
- Lab Results
- Insurance Cards (front and back)
- Current Medication
- Demographic Sheet
- History and Physical Report

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

- ANA (SLE)
- Comprehensive Metabolic Panel, CBC with differential w/in past 3 months