Alpha1 Proteinase Inhibitor, Human (Glassia)

Provider Order Form rev. 12/23/2021

Ph: (888) 209-8874 Fax: (833) 329-4738

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 a rate not to exceed 0.2 mL/kg/min with 5 micron infusion filter ☐ Other:______________________

☐ Patient is required to stay for 30-minute observation post IV
☐ Patient is NOT required to stay for observation time
☐ Refills: ☐ Zero / ☐ for 12 months /
☐ ________________
(if not indicated order will expire one year from date signed)

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) ☐ Current Medication ☐ History and Physical Report
☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

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