Alpha1 Proteinase Inhibitor, Human (Prolastin-C Liquid)

Provider Order Form rev. 12/01/2021

AleraCare
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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 emphysema due to severe hereditary deficiency of Alpha1-PIE88.01

☐Other: _____

MEDICATION ORDER

☐ **(Prolastin-C Liquid)** intravenous infusion with 5-15-micron infusion filter

- Dose: ☐ 60mg/kg (+/- 10%) ☐ Other: _____
- Frequency: ☐ IV weekly☐ Other: _____
- Rate: ☐ Administer up to 0.08ml/kg/min
  ☐ Other: _____
  (No less than 15mins)

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

SPECIAL INSTRUCTIONS

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