

ALPHA-1 ANTITRYPSIN THERAPY

(Including Prolastin and Glassia)



PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List <input type="checkbox"/> NKDA <input type="checkbox"/>	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
- AAT Level and Phenotype/Genotype
- Most Recent FEV1

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 FlexCare Infusion Centers' protocol (See flexcareinfusion.com 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 FlexCare Infusion Centers' protocol (See flexcareinfusion.com 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:	<input type="checkbox"/> Fax:
NPI AND License:	<input type="checkbox"/> Email:

Provider Signature

Date