

Alpha-1 Antitrypsin Therapy

(Prolastin-C, Glassia, Zemaira, Aralast NP)



PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Phone: _____
Date of Birth: _____ Address: _____
Allergies See List NKDA City, State, Zip: _____
Weight: _____ kg lbs Height: _____ in cm Email: _____

PRIMARY DIAGNOSIS

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

PRESCRIPTION

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

Has patient received any doses of this medication in the past? Yes No
Refill x 12 months unless otherwise noted: _____

REQUIRED DOCUMENTATION

- | | | | |
|------------------------|--------------------|--------------------|---|
| • Insurance Card | • IG Panel | • Hep B Panel | • AAT Level and Phenotype/Genotype |
| • H&P | • Medication List | • Most recent FEV1 | • For Prolastin-C referrals: Completed Prolastin Direct enrollment form |
| • Patient Demographics | • Most recent labs | | |

ANCILLARY ORDERS

ADVERSE REACTION & ANAPHYLAXIS ORDERS

Administer acute infusion and anaphylaxis medications per Advanced Infusion Care Centers' protocol (*See aiscaregroup.com for detailed policy*)

Other: Please fax other reaction orders if checking this box

PRE-MEDICATION ORDERS PROTOCOL

Per infusion center protocol: No recommended standard pre-meds.
Provider Prescribed: _____

LINE CARE ORDERS

Start PIV/Access CVC Flush device per Advanced Infusion Care Centers' protocol (*See aiscaregroup.com for detailed policy*)
Other Flush Orders: Please fax other line care orders if checking this box

LAB ORDERS—PLEASE INCLUDE FREQUENCY

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

PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____
NPI: _____ Fax: _____
Office Contact Person: _____ Email: _____
Prescriber Signature: _____ Date: _____
I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Fax: 855.217.1930 | Phone: 800.482.8466 | Email: AICCrefferrals@aiscaregroup.com | Visit: aiscaregroup.com/patient-referral-forms/