



ALPHA-1 ANTITRYPSIN THERAPY

(Including Prolastin and Glassia)

PATIENT INFORMATION

PATIENT NAME: _____ PHONE #: _____
ADDRESS: _____ CITY, STATE, ZIP: _____
DATE OF BIRTH: _____ EMAIL: _____
ALLERGIES: SEE LIST NKDA WEIGHT: LB OR KG

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- Hep B Panel
- IG Panel
- Most Recent FEV1
- AAT Level and Phenotype/Genotype
- For Prolastin referrals: Completed Prolastin Direct enrollment form

PRIMARY DIAGNOSIS

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

LABS 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?: Yes No Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

- Start PIV/ACCESS CVC Flush device per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)
 Other Flush Orders: Please send other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

- Administer acute infusion and anaphylaxis medications per Real Medix - Real Infusions protocol (See com for detailed policy)
 Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE: _____
OFFICE CONTACT: _____ FAX: _____
ADDRESS: _____ EMAIL: _____
CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

X

PROVIDER SIGNATURE _____ DATE _____