



PROLASTIN-C® (ALPHA-PROTEINASE INHIBITOR) ORDER FORM
(* - Required Fields)

STAT REQUEST
(*REASON MUST BE PROVIDED BELOW)

New Referral Order Renewal Medication/Order Change
 Benefits Verification Only Discontinuation Order

PATIENT INFORMATION			
NAME*:	DOB*:	SEX: M F	
ADDRESS:		PHONE:	
WEIGHT:	LBS KG	HEIGHT:	EMAIL:
ALLERGIES:			

PHYSICIAN INFORMATION			
PHYSICIAN NAME*:		PRACTICE NAME:	
ADDRESS:		OFFICE CONTACT*:	
PHONE:	FAX:	EMAIL (FOR UPDATES):	

PROLASTIN-C ORDER*: **ICD-10*:** _____
(SELECT ONE OF THE FOLLOWING)

Dosing: 60 mg/kg body weight intravenously once per week (+/- 10%)

Physician Signature* _____ Date*(Order is Valid for One Year) _____
Infusion will be administered per MPP policy and protocols

REQUIRED DIAGNOSIS:
<input type="checkbox"/> Alpha1 Antitrypsin Deficiency Emphysema
<input type="checkbox"/> Other _____

***STAT REASON:**
(STAT request will be assessed per MPP policy and protocol)

REQUIRED DOCUMENTATION CHECKLIST:
<input type="checkbox"/> Patient Demographics
<input type="checkbox"/> Insurance Card/Information
<input type="checkbox"/> Clinical/Progress Notes supporting DX
<input type="checkbox"/> Current Medication List and H&P

Last Infusion/Injection Date: _____

STANDING LAB ORDERS: CMP CBC

Labs to be drawn by Infusion Center Frequency _____

NOTES/ADDITIONAL COMMENTS:

Locations:

-----Colorado-----

Lakewood

-----Florida-----

Jacksonville
 Kissimmee
 Port St. Lucie
 Suncoast
 Winter Park

-----Texas-----

Arlington
 Cedar Hill
 Dallas
 Denton
 Ft. Worth
 Irving
 Rockwall
 Southlake
 Flower Mound
 Plano
 Tyler