Fax Referrals To: (855) 891-2191
Email Referrals To: referrals@vivoinfusion.com
Have a Question? (855) 478-1528

# PROLASTIN-C® (ALPHA-PROTEINASE INHIBITOR) ORDER FORM

*(* - Required Fields)*

☐ **STAT REQUEST**
**( *REASON MUST BE PROVIDED BELOW)**

☐ New Referral ☐ Referral Renewal ☐ Medication/Treatment 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 Infusion*:
*(SELECT **ONE** OF THE FOLLOWING)*

**ICD-10*:** _____

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

**Physician Signature*** _____ **Date*(Referral Valid for One Year)** _____

***NPI #** _____

*Infusion will be administered per VIVO policy and protocols*

**ICD-10 Description:**

***STAT REASON:**
(STAT requests will be assessed per VIVO policy and protocols)

**Last Infusion/Injection Date:** _____

**REQUIRED DOCUMENTATION CHECKLIST:**

- ☐ Patient Demographics
- ☐ Insurance Card/Information
- ☐ Progress Notes supporting DX
- ☐ Current Medication List and H&P

**STANDING LAB REQUEST (to be drawn by clinic):** ☐ CMP ☐ CBC *Frequency _____

*Additional comments/notes:*

## Locations:

**--------Colorado-------**
- ☐ Lakewood

**--------Florida---------**
- ☐ Jacksonville
- ☐ Kissimmee
- ☐ Port St. Lucie
- ☐ Suncoast
- ☐ Winter Park

**---------Ohio---------**
- ☐ Beachwood
- ☐ Middleburg Hts.
- ☐ Painesville
- ☐ Youngstown
- ☐ Westlake
- ☐ Fairlawn

**-------Oklahoma-------**
- ☐ Tulsa

**---------Texas---------**
- ☐ Arlington
- ☐ Cedar Hill
- ☐ Dallas
- ☐ Denton
- ☐ Ft. Worth
- ☐ Irving
- ☐ Rockwall
- ☐ Southlake
- ☐ Flower Mound
- ☐ Plano
- ☐ Tyler

REVISION DATE- 5/2022