

ALPHA-1 PROTEINASE INHIBITOR PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:



Patient Name:

Date of Birth:

Address:

Phone:

Height:

inches cm

Weight:

lbs kg

Clinical Information

Primary Diagnosis Description: Alpha-1 antitrypsin deficiency

ICD-10 Code: E88.01

Alpha-1 Proteinase Inhibitor Prescription

Select Product:

Aralast® NP

Glassia®

Zemaira®

Prolastin-C

Refill as directed x 1 year.

Infuse 60 mg/kg IV once weekly over 15 to 30 minutes (as determined by prescribing information).

Ancillary Orders

Anaphylaxis Kit

→ If this is a 1st dose, would you like Option Care Health to provide an Anaphylaxis kit with the 1st dose?
Yes - Please complete Anaphylaxis Physician Order (FR-PC-036) provided No

Medication Orders

Other: _____

IV Flush Orders

Peripheral: NS 2 to 3 mL pre-/post-use.

Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Lab Orders

No labs ordered at this time.

Other: _____

Skilled nurse to assess and administer and/or teach self-administration where appropriate via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature: _____ Date: _____

Prescriber Information

Prescriber Name:

Phone:

Fax:

Address:

NPI:

City, State:

Zip:

Office Contact:

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