Intravene - Zemaira Infusion Orders (rev 10/2015)

Please fax this form along with a copy of insurance cards to:
Fax (434) 455-5531 or Call (434) 947-3900 ext. 2172

PATIENT INFORMATION

Name _____
Address _____
City _____
State _____ Zip code _____
Home Phone # _____
Work Phone # _____
DOB _____SSN _____Sex_____
Height _____ Weight _____
Allergies _____
Primary Insurance _____
Secondary Insurance _____

REFERRING PHYSICIAN INFORMATION

Physician Name _____
Physician Address_____
_____
Physician Phone _____
Physician Fax _____
NPI# _____ DEA # _____
State License#_____

** ***Please fax copy of insurance cards*****
Current office visit notes if available
and this form to (434)- 455-5531

DIAGNOSIS: (ICD-10 required)

☐ _____ _____
☐ _____ _____
☐ _____ _____

Serum AAT Level:_____mg/dL or _____uM Date:_____
PFT: FEV,% Pred_____ O2 Therapy:_____l/min Date:_____
CXR/CT Results:_____Date_____
Phenotype:_____

Current or former smoker? Yes or No (circle one)
If former smoker, date stopped:_____

STANDARD ORDERS

☐ Prescription: Zemaira (Alpha,-Proteinase Inhibitor-Human) **HCPC Code-J0256
Ordered Dose:_____ mg
☐ Frequency: Weekly _____
☐ Other Frequency:_____
Refills: (Months):_____

Patient weight _____lbs _____kg (2.2 lb=1 kg)

Signature, prescribing MD _____ Date _____

Anaphylactic meds available at the chairside:
Epinephrine 1:1000 1mg ampule. Administer 0.5ml (0.5mg) by SQ injection upon order of MD
Hydrocortisone 100mg vial. Administer 100mg IV push upon order of MD
Diphenhydramine 50mg vial. Administer 50 mg IV push upon order of MD

VITAL SIGNS MONITORING PER INTRAVENE PROTOCOL