Intravene – Prolastin C Infusion Orders (rev 4/2022)

Please fax this form along with a copy of insurance cards to:
Fax (434) 455-5531 or Call (434) 947-3900 ext. 3001

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: Prolastin C (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)

ANAPHYLACTIC MEDS AND VITAL SIGNS MONITORING PER INTRAVENE PROTOCOL

Signature, prescribing MD ____________________________ Date __________________