

Prolastin-C

(Alpha-1 Antitrypsin)

Central Intake Fax: 800-504-0870

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight: _____ lbs or _____ kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- Tried/Failed Therapies
- History & Physical
- Patient Demographics
- Most Recent Labs
- IG Panel
- Medication List
- Most Recent FEV1
- AAT Level and Phenotype/Genotype
- For Prolastin referrals: Completed Prolastin Direct enrollment form

PRIMARY DIAGNOSIS

- ☐ E88.01 Alpha-1 antitrypsin deficiency
- ☐ J43.1 Panlobular emphysema
- ☐ J43.2 Centrilobular emphysema
- ☐ J43.8 Other emphysema
- ☐ Other: _____

PRIMARY MEDICATION ORDER ** If necessary, Suite Life will round dose up/down according to payor guidelines*

- ☐ Prolastin-C 60mg/kg (+/-10%) IV weekly
- ☐ Glassia 60mg/kg (+/-10%) IV weekly
- ☐ Other: _____

First Dose: ☐ Y ☐ N ☒ Refill x12 months unless otherwise noted:

LINE USE/CARE ORDERS

- ☒ Start PIV/ACCESS CVC ☒ Flush device per Suite Life Health's protocol (See suitelifehealth.com for detailed policy)
- ☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

- ☒ Administer acute infusion reaction and anaphylaxis medications per Suite Life Health's protocol (See suitelifehealth.com for detailed policy)
- ☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI AND License:	☐ Email:

Provider Signature

Date

Updated: 3/26

