

ALPHA1-PROTEINASE INHIBITORS, HUMAN Order Form

Outpatient Infusion

Patient Name							
DOB							
Address							
Phone							
Order Status		☐ New Order ☐ Renewal			☐ Dose or Frequency Change		
Diagnosis		☐ Alpha1-1-antitrypsin deficiency ☐ Other: ——————					Diagnosis Code:
		Allergies:					
Required Information		CBC, CMP	(include lab result docum	ents)	Date:		Weight: Height:
Labs (if applicable):							
Pre-Medications			,	□ 25mg		50mg	IV DPO
		· · · · · · · · · · · · · · · · · · ·		□ 325mg		□ 650mg □ PO	
		□ Other:					
		Drug Dos			Route Frequency		requency
Medication Order		Aralast NP Glassia Prolastin-C	□ 60 mg/kg		IV	Every weeks	
		Zemaira	□ Other:	□ Other:		□ Other:	
Infusion Reaction Medications Hypersensitivity Reaction Protocol will be utilized unless otherwise specified.							e specified.
Required Documentation H&P or progress note supporting diagnosis Medication history Recent labs (as above) and/or diagnostic test results							
Provider (print name):				Date:			
Provider Signature:				NPI:			
Office Phone:				Office Fax:			



OUTPATIENT INFUSION CENTERS

Select an Infusion Center below (check box):

- Glendale Infusion Clinic6220 W Bell Road, Glendale AZ 85308
- Osborn NSI Infusion Clinic7242 E Osborn Road Ste 340, Scottsdale AZ 85251
- Pima Infusion Clinic8405 N Pima Center Parkway Ste 201, Scottsdale AZ 85258

How to Refer:

- Fax the medication order form along with the selected infusion center form and all necessary documentation to central scheduling and call to set up patient information.
 - o Central Scheduling Phone: (623) 434-6138
 - o Central Scheduling Fax: (602) 331-5765