Site of Care
☐ Home Infusion
☐ Infusion Center
☐ Doctor's Office

Fax Referral to (855) 644-3687 or Email: Referrals@sandshealth.com

ALPHA 1-PROTEINASE INHIBITOR (HUMAN) ORDER FORM

☐ Aralast ☐ Glassia ☐ Zemaira
☐ OK to change to a suggested biosimilar above based on insurance or availability

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Mobile Number:_____

Patient Weight: _____ Patient Height: _____ Allergies: _____

Other Medications: _____

DIAGNOSIS (Provider must specify)

☐ Emphysema due to severe hereditary deficiency of Alpha1-PI (alpha1-antitrypsin deficiency), ICD 10: E88.01

☐ Other: _____

PRE-MEDICATION

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Benadryl 25mg PO ☐ Methylprednisolone (Solu-Medrol) _____ mg IVP

☐ Other:_____ Dose: _____ Route: _____

☐ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Alpha1-Proteinase Inhibitor (Human)	☐ 60 mg/kg body weight intravenously once per week	☐ IV	☐ once per week

☐ New Start Therapy ☐ Continuation of Therapy Date of last dose (if applicable): _____

LABS / SPECIAL INSTRUCTIONS

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Signature: _____ Date: _____

Prior to treatment – ensure the following information is complete and attached with referral:

☐ Demographics ☐ Labs and tests supporting diagnosis ☐ Office/progress notes

Order valid for 1 year from date of signature unless otherwise specified here: _____