INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Alpha1-Proteinase Inhibitor *(human)*

☐ Glassia ☐ Prolastin-C Liquid ☐ Zemaira
☐ Dispense as written (DAW) Will substitute for biosimilar or reference product based on insurance and availability unless DAW is checked.

PATIENT INFORMATION

Patient name _____ DOB _____
Mobile number _____ Patient weight _____ kg
Allergies _____
☐ Patient has known difficult venous access. Comments: _____
☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

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

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____
Signature _____ Date _____
Contact name _____ Phone _____ Fax _____
Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

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

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

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

LABS / SPECIAL INSTRUCTIONS

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