

Alpha1-Proteinase Inhibitors, Human

Provider Order Form rev. 5/20/2022



www.vascoinfusion.com
ph: 602-346-0204 fax: 877-637-6691

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Patient Phone: _____ Patient Email: _____

NKDA Allergies: _____ Weight lbs/kg: _____ Height: _____

Patient Status: New to Therapy Continuing Therapy Therapy Change Next Due Date (if applicable): _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

DOCUMENTATION (REQUIRED)

| Labs | Insurance Card (front and back) | Current Medications | History/Progress Notes |
|------|---------------------------------|---------------------|------------------------|
|------|---------------------------------|---------------------|------------------------|

ICD-10 CODE

E88.01 Alpha1-1-antitrypsin deficiency

Other: _____

MEDICATION ORDER

Alpha1-Proteinase Inhibitors, Human

(choose one medication)

- Aralast NP
- Glassia
- Prolastin-C
- Zemaira

Dose:

60mg/kg IV

Other: _____

Frequency:

weekly

Other: _____

Order Expiration Date (mm/dd/yy): _____

(If not indicated order will expire one year from date signature)

PRE-MEDICATION ORDERS

acetaminophen (Tylenol) 500mg 650mg 1000mg PO

cetirizine (Zyrtec) 10mg PO

loratadine (Claritin) 10mg PO

diphenhydramine (Benadryl) 25mg 50mg / PO IV IV

methylprednisolone (Solu-Medrol) 40mgIV 125mg IV

hydrocortisone (Solu-Cortef) 100mg IV

Other: _____

Dose: _____ Route: _____ Frequency: _____

SPECIAL INSTRUCTIONS

Provider Name (Print)

Provider Signature

Date

Check here if this is a stat order