Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Referral Status:	MRN:
☐ New referral ☐ Order change ☐ Order Renewal	
Patient preferred clinic:	

Alpha-1-Antitrypsin Deficiency Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:				Patient's Phone:			
Patient Name:				Address:			
Date of Birth:				City, State, Zip:			
Height in inches:	Weight:	LB or	KG	Gender:	Allergies:	☐ See list	☐ NDKA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐	E88.01 - Alpha-1-Antitrypsin Deficiency	☐	J43.8 - Other Emphysema
☐	J43.2 - Panlobular Emphysema	☐	J43.1 - Centrilobular Emphysema
☐	_____ - Other:		

REQUESTED DOCUMENTATION:

1	Insurance information
2	Most recent History & Physical
3	Full medication list
4	Tried and failed therapies
5	Alpha-1 Anti-trypsin (AAT) blood testing
6	

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO: PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

IF YES:
LAST INFUSION DATE:
NEXT INFUSION DATE:

IF ORDER CHANGE:

☐ **Continue current order until insurance approved**

MEDICATION ORDERS:

NOTE: We may require a detailed Letter of Medical Necessity or clinical supporting documentation (depending on diagnosis), to be able to verify eligibility and payment for this treatment through Medicare and/or other insurance plans.

MEDICATION/DOSE:

☐ Glassia® 60mg/kg (+/- 10%) IV over at least 15 - 30 minutes via pump with filter as directed
☐ Other dose:_____

☐ Prolastin-C® 60mg/kg (+/- 10%) IV over at least 15 - 30 minutes via pump with filter as directed
☐ Other dose:_____

☐ Aralast NP™ 60mg/kg (+/- 10%) IV over at least 15 - 30 minutes via pump with filter as directed
☐ Other dose:_____

If vial size is not within 10% of the patients dose, the dose will be rounded up to the nearest whole vial size

FREQUENCY:

☐ Every 1 week.
☐ Other:_____

SPECIAL/LAB ORDERS:

☐ _____

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC
☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE
Dispense as written/Brand medically necessary	Substitution permitted	