immersiv HEALTH

ALPHA 1 PROTEINASE INHIBITOR ORDER FORM

FAX TO: 855.694.4656

PATIENT INFORMATION

PATIENT NAME: _____ **PHONE:** _____

DATE OF BIRTH: _____ **SEX:** ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ ☐ LBS ☐ KG

ALLERGIES: _____ **PREFERRED CLINIC:** _____

REFERRAL STATUS: ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

- ☐ E88.01 Alpha-1-antitrypsin deficiency
- ☐ J43.1 Panlobular emphysema
- ☐ J43.2 Centrilobular emphysema
- ☐ J43.8 Other emphysema
- ☐ J43.9 Emphysema, unspecified
- ☐ ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

☐ Insurance Information ☐ List of Medications ☐ Tried & failed Therapies ☐ Most recent History & Physical ☐ Alpha-1 Antitrypsin (AAT) blood testing

MEDICATION ORDER

***PRODUCT SELECTION BASED ACCORDING TO AVAILABILITY & PAYOR GUIDELINES**

If specific product required, indicate here: _____

ALPHA1 PROTEINASE INHIBITOR

- ☐ 60 mg/kg (+/- 10%) IV over 30 minutes weekly
- ☐ **OTHER:** _____

*If vial assay not within 10% of patient dose, the dose will be rounded up to the nearest whole vial

LAB ORDERS

LAB: _____ FREQUENCY: _____

☑ REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: _____

Patient to be observed for 30 minutes following the first injection.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ **NPI #:** _____

EMAIL: _____ **PHONE:** _____ **FAX:** _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: _____ **CONTACT NAME:** _____
(IF APPLICABLE)

SIGNATURE: _____ | _____ **DATE:** _____
(NO STAMPS)
SUBSTITUTION PERMITTED DISPENSE AS WRITTEN