BluHaven HEALTH

Alpha-1 Antitrypsin Referral Form

Fax: (984) 370-2352
Phone: (984) 370-2350
Email: connect@bluhaven.com

Patient Information

Name: _____ DOB: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Weight: _____ ☐ lbs ☐ kgs

Allergies: ☐ NKDA ☐ _____

Required Documentation Insurance Card | History & Physical | Patient Demographics | Most Recent Labs | Medication List
Hep B Panel | IG Panel | Most Recent FEV1 | AAT Level and Phenotype/Genotype |
For Prolastin referrals: Completed Prolastin Direct Enrollment Form

Primary Diagnosis

☐ E88.01 Alpha-1 antitrypsin deficiency
☐ J43.1 Panlobular emphysema
☐ J43.2 Centrilobular emphysema
☐ J43.8 Other emphysema
☐ Other: _____

Order Information

Lab Orders (Include frequency)

Please list any labs to be drawn by the infusion clinic: _____

Pre-Medications

☑ Per infusion clinic protocol: No recommended standard pre-meds for Prolastin or Glassia
☐ Provider Prescribed: _____

Primary Medication Order

☐ Aralast NP 60mg/kg (+/-10%) IV weekly
☐ Glassia 60mg/kg (+/-10%) IV weekly
☐ Prolastin-C 60mg/kg (+/-10%) IV weekly
☐ Other: _____

First Dose: ☐ Yes ☐ No ☑ Refill x12 months unless otherwise noted: _____

Line Use/Care Orders

☑ Start PIV/ACCESS CVC ☑ Flush device per BluHaven Health's protocol (see BluHaven.com for policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box.

Adverse Reaction & Anaphylaxis Orders

☑ Administer acute infusion reaction and anaphylaxis medications per BluHaven Healths' protocol (see BluHaven.com for policy)
☐ Other: Please fax other reaction orders if checking this box.

Provider Information

Name: _____ Office Contact: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Email: _____ NPI: _____

I authorize BluHaven Health and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this order and any future related orders for the patient listed above.

Provider Signature *Date*