

Chicago Illinois  
4711 Golf Road  
Suite 900  
Skokie, IL 60076



# PROLASTIN®

Date: \_\_\_\_\_

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
Allergies:	Date of Referral:	

PHYSICIAN INFORMATION		
Physician Name*:	Practice Name:	
Address:	Office Contact*:	
Phone:	Fax:	Email (for updates):

REFERRAL STATUS				
<input type="checkbox"/> New Referral	<input type="checkbox"/> Referral Renewal	<input type="checkbox"/> Medication/Order Change	<input type="checkbox"/> Benefits Verification Only	<input type="checkbox"/> Discontinuation Order

## PROLASTIN\*:

(SELECT ONE OF THE FOLLOWING)

\_\_\_ Dosing: 60 mg/kg body weight intravenously once per week (+/- 10%)

Physician Signature \_\_\_\_\_ Date (Order is Valid for One Year) \_\_\_\_\_

REQUIRED DIAGNOSIS:
___ Alpha1 Antitrypsin Deficiency Emphysema
___ Other _____

REQUIRED DOCUMENTATION CHECKLIST:
___ Patient Demographics
___ Insurance Card/Information
___ Clinical/Progress Notes supporting DX
___ Current Medication List and H&P
Last Infusion/Injection Date: _____

STANDING LAB ORDERS Labs to be drawn by Infusion Center \_\_\_\_\_ Frequency \_\_\_\_\_

NOTES/ADDITIONAL COMMENTS:

## ORDERING PROVIDER

Signature **X** \_\_\_\_\_ Date \_\_\_\_\_

Provider \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_