Connecticut
500 W Putnam Ave
Ste 435
Greenwich, CT 06830

Office: 212-803-3339 Fax : 646-768-8600

PROLASTIN®

Date: ____________________

PATIENT INFORMATION		
Name:	DOB:	SEX: M ☐ F ☐
Allergies:	Date of Referral:	

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

REFERRAL STATUS

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐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 ___________