

Vermont
28 Park Ave
Suite #1A
Williston, VT 05495



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 _____