Lexington
1792 Alysheba Way
Suite 205
Lexington, KY 40509

Bowling Green
727 U.S. 31 W Bypass
Suite 102
Bowling Green, KY 42101

ThrIVewell™
INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

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 _____