

**PATIENT INFORMATION**

PATIENT NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SEX:  M  F HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_  LBS  KG

ALLERGIES: \_\_\_\_\_ PREFERRED CLINIC: \_\_\_\_\_

REFERRAL STATUS:  NEW REFERRAL  ORDER CHANGE  ORDER RENEWAL

**DIAGNOSIS & CLINICAL DOCUMENTATION**

E88.01 Alpha-1-antitrypsin deficiency

J43.1 Panlobular emphysema

J43.2 Centrilobular emphysema

J43.8 Other emphysema

J43.9 Emphysema, unspecified

ICD-10 CODE: \_\_\_\_\_ DESCRIPTION: \_\_\_\_\_

**REQUIRED DOCUMENTATION**

Insurance Information

List of Medications

Tried & failed Therapies

Most recent History & Physical

Alpha-1 Antitrypsin (AAT) blood testing

**MEDICATION ORDER**

\*Product selection based according to availability & payor guidelines

If specific product required, indicate here: \_\_\_\_\_

Alpha1 Proteinase Inhibitor

60 mg/kg (+/- 10%) IV over 30 minutes weekly

OTHER: \_\_\_\_\_

\*If vial assay not within 10% of patient dose, the dose will be rounded up to the nearest whole vial

**LAB ORDERS**

LAB: \_\_\_\_\_ FREQUENCY: \_\_\_\_\_

REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: \_\_\_\_\_

Patient to be observed for 30 minutes following the first injection. Administer per protocol.  
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

**PRESCRIBER INFORMATION**

PROVIDER NAME: \_\_\_\_\_ NPI #: \_\_\_\_\_

EMAIL: \_\_\_\_\_ PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

ADDRESS (INCLUDE CITY, STATE, ZIP): \_\_\_\_\_

SUPERVISING PHYSICIAN: \_\_\_\_\_ CONTACT NAME: \_\_\_\_\_  
(IF APPLICABLE)

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(NO STAMPS)

SUBSTITUTION PERMITTED

DISPENSE AS WRITTEN