Alpha1 Proteinase Inhibitor, Human (Aralast, Glassia, Prolastin-C)

Provider Order Form *rev. 11/06/26*

arbor infusion

PATIENT INFORMATION

Referral Status: ☐New Referral ☐Updated Order ☐Order Renewal

Patient Name: DOB: Mobile Phone Number:

Weight (lbs/kg): ☐NKDA Allergies:

Therapy Status: ☐New to Therapy ☐Continuing Therapy Last Treatment Date: Next Due Date:

REQUIRED SUPPORTING DOCUMENTATION *(Please include the following with the order to support processing & insurance approval)*

• Patient demographics • Office/progress notes supporting diagnosis including treatment failures • Labs & tests supporting diagnosis • Insurance card(s)

DIAGNOSIS ICD-10 CODE *(Provider must specify)*

☐E88.01 Emphysema due to severe hereditary deficiency of Alpha1-PI (alpha1-antitrypsin deficiency)

☐Other:

PRIMARY MEDICATION ORDER

Arbor Infusion will select the product based on payor requirements and product availability. Products include Aralast NP, Glassia, Prolastin-C Liquid.

Alpha-1 proteinase inhibitor, Human

- Prepare and administer medication in accordance with the manufacturer's prescribing information. Infuse at the rate recommended by the manufacturer
- Flush with 0.9% sodium chloride at the completion of infusion
- *(If Prolastin-C is selected by Arbor Infusion, dosing may be adjusted within the prescribing information allowance of 60 mg/kg ±10%.)*

☐Infuse this specific Alpha1 product: _____

• Refill for 12 months unless otherwise noted: _____

PRODUCT	DOSE	FREQUENCY	RATE
Aralast NP	60 mg/kg	Once IV weekly	Administer up to 0.2 ml/kg/min
Glassia	60 mg/kg	Once IV weekly	Administer up to 0.2 ml/kg/min
Prolastin-C	60 mg/kg (± 10%)	Once IV weekly	Administer up to 0.08 ml/kg/min

SPECIAL INSTRUCTIONS

PRE-MEDICATION

Note: pre-meds not typically indicated

☐acetaminophen (Tylenol) ☐500mg / ☐650mg / ☐1000mg PO

☐cetirizine (Zyrtec) 10mg PO

☐loratadine (Claritin) 10mg PO

☐famotidine (Pepcid) 20 mg IV

☐diphenhydramine (Benadryl) ☐25mg / ☐50mg ☐PO / ☐IV

☐methylprednisolone (Solu-Medrol) ☐40mg / ☐125mg IV

☐Other: _____

Dose: _____ Route: _____

LABORATORY ORDERS

☐CBC ☐at each dose ☐every _____

☐CMP ☐at each dose ☐every _____

☐Other: _____

NURSING

• Provide nursing care per Arbor Infusion Nursing Procedures, including reaction management and post-procedure observation

APPEALS PROCESS

Upon denial, Arbor Infusion will appeal with a Letter of Medical Necessity unless you opt out: ☐Opt out (I will manage any denial)

Ordering Provider (Print) **Provider Signature** **Provider NPI** **Date**

☐No change to practice information since the most recent referral or order. If checked, the additional practice information section below may be left blank.

PRACTICE INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zipcode:

ARBOR INFUSION FAX NUMBERS *(Submit a signed order and supporting documentation via fax or email orders@arborinfusion.com)*

☐Arbor Infusion Fishers (317) 981-1772

☐Arbor Infusion Carmel (317) 981-1772