

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

Provider Order Form rev. 8/23/26



## 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  $\pm$  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 ( $\pm$ 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](mailto:orders@arborinfusion.com))

☐ Arbor Infusion Fishers (317) 981-1772