PROLASTIN® C (ALPHA$_1$ – PROTEINASE INHIBITOR (HUMAN)) Referral Form FAX (855) 891-2191

Effective: 10/2016

MPP Infusion Centers

www.mppinfusion.com

Referral Phone: (855) 478-1528 Referral Fax: (855) 891-2191

☐ Denver ☐ Arlington ☐ Dallas ☐ Duncanville ☐ Irving ☐ Lewisville ☐ Plano ☐ Southlake

☐ New Referral ☐ Restart ☐ Medication/ Order Change *(New Order Required)* ☐ Benefits Verification Only ☐ D/C Infusions **indicate name of drug(s)*

_____

PATIENT INFORMATION

Name: _____ Date: _____

DOB: _____ SS# _____

Phone # _____

Email: _____

PHYSICIAN INFORMATION

Referring Physician: _____

Practice Name: _____

Specialty: _____

Office Contact: _____

Contact Phone # _____ Contact Fax # _____

Contact Email: _____

PROLASTIN® C MEDICATION ORDERS

Dosing: 60 mg/kg IV **weekly**

INDICATION/DIAGNOSIS

☐ Alpha$_1$ Antitrypsin Deficiency Emphysema

***ICD-10** _____ **required**

_____ _____

Referring Physician's Signature Date

NOTES (ADDITIONAL INFO)

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report

☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

ATTACH REQUIRED LAB RESULTS

☐ Deficient ATT Genotype

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY