Alpha-1-Proteinase Inhibitor Order Form

Select referral location:

Akron
Athens
Cincinnati (Blue Ash)
Cincinnati (West)
Cleveland
Columbus (East Broad)
Columbus (Hilliard)
Columbus (Worthington)
Dayton (Beavercreek)
Dayton (Englewood)
Findlay
Liberty
Mansfield
Perrysburg
Springfield
Toledo
Crestview Hills (NKY)

For new referrals, please include recent labs and last two office visit notes.

Fax completed form to 888-977-0914

Phone: 877-787-8720 • www.horizoninfusions.com

1. PATIENT INFORMATION

Name:
DOB:
Phone:
Other Phone:
Email:
Social Security #:
Allergies:
Gender: M F
Weight: Lbs Kg
Patient Status: New to therapy Continuing therapy Next due date *(if applicable)*:

2. INSURANCE INFORMATION *(required)*

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

3. PHYSICIAN INFORMATION

Physician Name:
NPI#:
License #:
TIN#:
DEA#:
Address:
City:
State
Zip
Office Contact:
Email:
Office phone:
Office fax:

4. DIAGNOSIS INFORMATION *(and year of diagnosis)*

Emphysema (________) Alpha Antitrypsin Deficiency (_______) ICD 10 (_______) Other: __________________

5. PRESCRIPTION INFORMATION *(requires new order every 12-months)*

ARALAST GLASSIA
Administer 60mg/kg IV once per week

PROLASTIN-C
Administer 60mg/kg (+/- 10%) IV once per week

Vital signs per HI Protocol
Anaphylaxis & Hydration Management per HI Protocol

PRE-MEDICATIONS N/A
Acetaminophen 500mg 650mg 1000mg
Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)
Diphenhydrimine (Benadryl) 25mg 50mg PO IV (requires driver)
Methylprednisolone (Solu-Medrol) 40mg 80mg 125mg IV
Prednisone ___________ mg PO
Other ________________________________

POST-MEDICATIONS N/A
Acetaminophen 500mg 650mg 1000mg
Prednisone __________ mg PO
Other ________________________________

6. LABS

CBC w/Diff Each Infusion Other Frequency (*specify*): ______________________________
CRP Each Infusion Other Frequency (*specify*): ______________________________
CMP Each Infusion Other Frequency (*specify*): ______________________________
ESR Each Infusion Other Frequency (*specify*): ______________________________
Hepatic Panel Each Infusion Other Frequency (*specify*): ______________________________
Renal Panel Each Infusion Other Frequency (*specify*): ______________________________
Quantiferon TB Gold, annually, last completed *(date)*: ____
Other (*specify*):____

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE