



Prolastin® Infusion Order Form

Please include the following (required):

1. Patient Demographics & Insurance Information
2. Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (ICD-10)

Patient Name

DOB

Allergies

Weight

Patient Phone

Primary Diagnosis

- Alpha-1 Antitrypsin Deficiency _____ Panacinar Emphysema _____
 Other: ICD-10 Code: _____ Description: _____

Prescription Orders:

Prolastin® (Alpha1 – Proteinase Inhibitor) (Quantity: _____ mg per kg +/- 10%)

Reconstitute just prior to infusion with 40ml sterile water and pool into Empty IV Bag for infusion as directed below.

Sig: Infuse _____ over _____ minutes every _____ weeks

Refill for 12 months.

I authorize NTIDC to use their protocol for reactions in the office.

Physician Name

Phone

Fax

Physician's signature

Date

**Fax completed form to (214) 887-0436. For insurance questions call (214) 276-5642.
 For any other questions please call (469) 480-9649.
 Or visit us online at www.ntinfusioncenters.com**