Infusion ASSOCIATES

Phone: (833) 394-0600 Fax: (833) 996-4888

Aralast NP IV Infusion

*Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, Current Medications and **Recent Visit Notes***

Referral status: ☐ NEW referral ☐ Dose or frequency change ☐ Order renewal

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:**_____

ICD-10 : _____, _____, _____

In the past year, what medications for the above diagnosis has the patient tried and failed?
☐ N/A continuation of treatment

Drug	Dose	Dates of use

Does the patient have emphysema? ☐ No ☐ Yes
What is the patient's baseline percent predicted FEV_1 _____
What is the patient's baseline serum AAT level? _____

Labs to be collected: ☐ BMP ☐ CMP ☐ CBC w/o diff ☐ CBC w/diff ☐ CBC w/man diff ☐ Other: _____

Lab Frequency: ☐ EVERY infusion ☐ Every OTHER infusion ☐ Other:_____

Aralast NP (alpha$_1$-proteinase inhibitor) IV

Dosage: 60 mg/kg Other:_____

Frequency: Every Week

Date of last infusion if not at IA:_____ **Expiration Date:** _____/_____/_____

Printed Provider Name: _____

Provider Signature: _____

Office Phone Number: _____**Office Fax Number:** _____

Contact Name: _____**Contact Phone Number:** _____

New referring providers, how did you hear about us? ☐Web Search ☐Pharma Rep ☐Drug Locator ☐Patient ☐Word of Mouth ☐IA Clinical Liaison ☐IA Website ☐Facebook ☐Instagram ☐TV/streaming ☐ Other: _____