TwelveStone Health Partners
Fax Referral To: (615) 278-3355
Direct Phone: (844) 893-0012
Email: intake@12stonehealth.com

ALPHA-1 ANTITRYPSIN DEFICIENCY ORDER FORM

Date: _____ ICD-10 Code: _____

Patient Name: _____ Allergies: _____

Date of Birth: _____ Weight: _____ lbs OR _____ kg

Therapy Status

☐ New Start

☐ Continuing Therapy:
Last Dose: _____

Provider Information

Ordering Provider: _____ Provider Fax: _____

Provider NPI: _____ Provider Address: _____

Provider Phone: _____

MEDICATION ORDER

☐ Alpha-1 Antitryspin Deficiency Agent *Therapeutic interchange to insurance preferred medication authorized unless otherwise specified below:* ☐ Glassia ☐ Aralast NP ☐ Prolastin *(non-preferred agent; please allow 1-2 weeks additional processing time to begin therapy)*	✓ 60mg/kg IV to be given weekly per protocol. ✓ Glassia and Aralast NP: Administer at a rate not to exceed 0.2mL/kg/min as determined by patient tolerance. ✓ Prolastin: Administer at a rate not to exceed 0.08mL/kg/min as determined by patient tolerance. ✓ TwelveStone pharmacy to verify rate per individual patient and maintain a +/- 10% margin of error on weight-based dose.	Refills for one year from date of signature unless indicated below. _____ Refills	Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion: ✓ IgA Level

PRE-MEDICATIONS

Oral

- ☐ Acetaminophen: _____325mg _____500mg _____650mg
- ☐ Loratadine: 10mg
- ☐ Cetirizine: 10mg
- ☐ Diphenhydramine: _____25mg _____50mg
- ☐ Famotidine: _____20mg _____40mg
- ☐ Ibuprofen: _____ 200mg _____400mg_____600mg
- ☐ Ondansetron: _____4mg _____ 8mg
- ☐ Other: _____

IV

- ☐ Dexamethasone: _____4mg _____8mg
- ☐ Diphenhydramine: _____25mg_____50mg
- ☐ Famotidine: _____20mg_____40mg
- ☐ Methylprednisolone: 125mg
- ☐ Hydrocortisone: 100mg
- ☐ Ondansetron: _____4mg _____8mg
- ☐ Other: _____

LAB ORDERS (please indicate any labs to be drawn and frequency)

Surveillance lab ordering and monitoring is the responsibility of the prescriber

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

By signing below, I certify that the above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

Dispense as Written:

_____ _____
Prescriber Name Date

Substitution Allowed:

_____ _____
Prescriber Name Date