NORTH TEXAS INFUSION CENTERS

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 _____mg 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.Contact us directly at: (214) 276-5642.
Or visit us online at www.ntinfusioncenters.com