



MOUNTAIN GRACE
— HOME INFUSION —

+1 833-360-1212 info@mginfusion.com

+1 (760) 400-6905

ALPHA-1 PROTEINASE INHIBITORS

Glassia, Prolastin-C, Zemaira, Aralast NP

Date of order: _____

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Update Order ☐ Order Renewal

Date: _____ Patient Name: _____ Patient Phone: _____ DOB: _____

ICD-10 code (required): ☐ E88.01 ICD Description: _____

Allergies: _____ Weight (lbs/kg): _____ Height: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: info@managecaresolutions.com

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip: _____

NURSING

☒ Center will use Hypersensitivity protocol established by Mountain Grace Home Infusion and PI

THERAPY ADMINISTRATION

☒ Alpha-1 Proteinase Inhibitor Intravenous Infusion

☐ Preferred Brand: _____

☐ Administer 60mg/kg once weekly

Mountain Grace Home Infusion will round the dose to the nearest vial if it is within +/- 10% of calculated dose, otherwise we will give exact dose

☐ Refills: ☐ Zero/ ☐ for 12 months/ ☐ _____
(if not indicated order will expire one year from date signed)

To receive the brand-name medication, the prescribing provider must clearly write "Brand Medically Necessary" on the prescription. If this notation is absent, I4H may dispense an FDA-approved generic equivalent or biosimilar, when available.

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ Other _____ ☐ Frequency _____

☐ Please check this box if you DO NOT authorize Mountain Grace Home Infusion to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

PRE-MEDICATION ORDERS

Pre-meds not usually indicated

☐ Diphenhydramine ☐ 25mg / ☐ 50 mg ☐ PO / ☐ IV
☐ Acetaminophen ☐ 325mg / ☐ 500mg / ☐ 650 mg PO
☐ Other: _____

Dose: _____ Route: _____ Frequency: _____

SPECIAL INSTRUCTIONS:

Provider Name (Print): _____

Provider Signature: _____

Date: _____

Please send it to this email: info@mginfusion.com