Alpha$_1$-Proteinase Inhibitor, Human

(Prolastin-C Liquid, Aralast NP, Glassia)

Provider Order Form *rev. 12/26/2025*

AMERICAN INFUSION CARE
SPECIALTY INFUSION

PATIENT INFORMATION **Referral Status:** ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Full Name: _____ DOB:_____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

☐ NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

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

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Primary diagnosis)

☐ E88.01 Alpha-1 antitrypsin deficiency ☐ J43.1 Panlobular emphysema ☐ J43.2 Centrilobular emphysema

☐ Other: _____

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.
Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications

☐ Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mgPO
☐ Cetirizine (Zyrtec) 10mgPO
☐ Loratadine (Claritin) 10mgPO
☐ Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV
☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV
☐ Hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____ Dose: _____ Route: _____ Frequency: _____

Lab Orders

Required: Alpha-1 antitrypsin (AAT) protein blood testing, genetic testing results, pulmonary function tests, &/or CT scan
**For Prolastin referrals: Completed Prolastin enrollment form*
☐ Other: _____

Alpha-1 Proteinase Inhibitor, Human (Select one)**:**

☐ **Aralast-NP IV:**
☐ Dose: 60mg/kg (+/- 10%) ☐ Other: _____mg/kg (+/- 10%) Rate: over at least 30 minutes or at a maximum rate of 0.2 mL/kg/min

☐ **Glassia IV:**
☐ Dose: 60mg/kg (+/- 10%) ☐ Other: _____mg/kg (+/- 10%) Rate: over at least 30 minutes or at a maximum rate of 0.2 mL/kg/min

☐ **Prolastin-C IV:**
☐ Dose: 60mg/kg (+/- 10%) ☐ Other: _____mg/kg (+/- 10%) Rate: over at least 30 minutes or at a maximum rate of 0.08 mL/kg/min

Frequency (Select one)**:**
☐ Once IV Weekly ☐ Every _____ week(s) for one year

Is the patient on any other disease modifying therapy? ☐ yes ☐ no
If yes, please note therapy and last dose: _____

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.
Special Instructions: _____
(If not indicated the medication order will expire one year from date signed)

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

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

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

_____ _____ _____
Provider Name (Print) *Provider Signature* *Date*

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Harlingen F: 956.341.9687 P: 832.800.3213 Laredo F: 956.306.3715 P: 832.800.3213
Other Locations (Oaklawn, Lancaster, etc): F: 469.305.2361 P: 972.865.4454