

**Prolastin C Enrollment Form**

**TwelveStone Health Partners**

**Fax Referral To:  
(800) 223-4063**



Date: \_\_\_\_\_  
 Patient Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_

Direct Phone: (615) 278-3350  
 Toll Free: (844) 893-0012

**PREVIOUS ADMINISTRATION**

<b>If YES, please provide the following information:</b>	<b>If NO, please indicate desired location for first dose:</b>
Last Infusion Date: _____	<input type="checkbox"/> Physician's Office
Next Infusion Date: _____	TwelveStone Infusion Center:
	<input type="checkbox"/> Canton <input type="checkbox"/> Chattanooga <input type="checkbox"/> Knoxville <input type="checkbox"/> Mount Juliet <input type="checkbox"/> Murfreesboro
	<input type="checkbox"/> Other: _____
	Desired Start Date: _____

**DIAGNOSIS**

<b>Description</b>	<b>ICD-10 Code</b>
<input type="checkbox"/> Alpha 1 Anti-Trypsin Deficiency	<input type="checkbox"/> E88.01

**OTHER REQUIRED DOCUMENTATION (Please attach documents as needed)**

<input type="checkbox"/> This signed order form	<input type="checkbox"/> History and Physical
<input type="checkbox"/> Patient Demographics and Insurance Information	<input type="checkbox"/> Clinical progress notes, lab work (including most recent renal function tests and any other tests supporting primary diagnosis)

**CLINICAL INFORMATION (Please attach all clinical information, lab results and other medical history documents)**

Patient Weight: \_\_\_\_\_ Kg    Height: \_\_\_\_\_ Inches/CM    BSA: \_\_\_\_\_    Allergies: \_\_\_\_\_

Line Access:    PIV    PICC (SL DL TL)    PORT (Huber size \_\_\_\_\_ Gauge \_\_\_\_\_ Length)    Sub-Q

MEDICATION	DIRECTIONS	REFILLS	BASELINE LABWORK REQ'D TO INITIATE (check for Twelvestone to draw)
<input type="checkbox"/> Prolastin C	<input type="checkbox"/> Infuse 60mg/kg (____mg) IV every week at a rate of 0.08mL/kg/min. (TwelveStone Pharmacy to verify rate per individual patient and maintain an +/-10% margin of error on weight-based dose. )		<input type="checkbox"/> IgA Level

**LAB ORDERS - To be drawn by TwelveStone**

<u>Order</u>	<u>Frequency</u>
CBC w/Differential	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q ____ Weeks <input type="checkbox"/> Other _____
CBC w/o Differential	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q ____ Weeks <input type="checkbox"/> Other _____
CMP	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q ____ Weeks <input type="checkbox"/> Other _____
BMP	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q ____ Weeks <input type="checkbox"/> Other _____
CRP	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q ____ Weeks <input type="checkbox"/> Other _____
Sed Rate	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q ____ Weeks <input type="checkbox"/> Other _____
Calcium	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q ____ Weeks <input type="checkbox"/> Other _____
Tb QuantiFERON Gold	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q ____ Weeks <input type="checkbox"/> Other _____
Hepatitis Panel	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q ____ Weeks <input type="checkbox"/> Other _____
Other _____	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q ____ Weeks <input type="checkbox"/> Other _____

**PRE-MEDICATIONS - If No Pre-Meds please check here \_\_\_\_\_**

<u>Oral</u>	<u>IV</u>
Acetaminophen: <input type="checkbox"/> 325mg <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg	Dexamethasone: <input type="checkbox"/> 4mg <input type="checkbox"/> 8mg
Cetirizine: <input type="checkbox"/> 10mg	Diphenhydramine: <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg
*Diphenhydramine: <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg	Famotidine: <input type="checkbox"/> 20mg <input type="checkbox"/> 40mg
Famotidine: <input type="checkbox"/> 20mg <input type="checkbox"/> 40mg	Methylprednisolone: <input type="checkbox"/> _____mg IV over _____ mins
Ibuprofen: <input type="checkbox"/> 200mg	Ondansetron: <input type="checkbox"/> 4mg <input type="checkbox"/> 8mg
Loratadine: <input type="checkbox"/> 10mg	
Ondansetron: <input type="checkbox"/> 4mg	

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

Physician's Phone # _____	Physician's NPI# _____	Physician's Fax # _____	Physician's Address _____
Dispense as Written _____	Date _____	Substitution Allowed _____	Date _____

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