

ARALAST NP ORDER FORM

Date: _____	ICD-10 Code: _____	<p align="center">Therapy Status</p> <input type="checkbox"/> New Start <input type="checkbox"/> Continuing Therapy: Last Dose: _____
Patient Name: _____	Allergies: _____	
Date of Birth: _____	Weight: _____ lbs OR _____ kg	

Provider Information

Ordering Provider: _____	Provider Fax: _____
Provider NPI: _____	Provider Address: _____
Provider Phone: _____	

MEDICATION ORDER

Aralast NP	<input checked="" type="checkbox"/> Aralast NP 60mg/kg IV to be given weekly. Administer at a rate not to exceed 0.2mL/kg per minute as determined by patient tolerance. <input checked="" type="checkbox"/> TwelveStone pharmacy to verify rate per individual patient and maintain a +/- 10% margin of error on weight-based dose.	Refills x one year from date of signature unless indicated below. <input type="checkbox"/> _____ Refills	<p><i>Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:</i></p> <input checked="" type="checkbox"/> IgA Level
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PRE-MEDICATIONS

<p><u>Oral</u></p> <input type="checkbox"/> Acetaminophen: _____ 325mg _____ 500mg _____ 650mg <input type="checkbox"/> Loratadine: _____ 10mg <input type="checkbox"/> Cetirizine: _____ 10mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Ibuprofen: _____ 200mg _____ 400mg _____ 600mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____	<p><u>IV</u></p> <input type="checkbox"/> Dexamethasone: _____ 4mg _____ 8mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Methylprednisolone: 125mg <input type="checkbox"/> Hydrocortisone: 100mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____
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LAB ORDERS (please indicate any labs to be drawn and frequency)

OTHER REQUIRED DOCUMENTATION

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) <ul style="list-style-type: none"> • History & Physical, Last Office Visit Note • Patient Demographics and Insurance Information • Medication List • Recent Lab Work
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By signing below, I certify that the above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

Dispense as Written:	Substitution Allowed:
_____ Prescriber Name	_____ Prescriber Name
_____ Date	_____ Date