Alpha1-proteinase Inhibitor (Prolastin-C)

Provider Order Form rev. 7/30/2025

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Alpha1-antitrypsin deficiency:

Other:

THERAPY & DOSING

☑ Administer Prolastin-C 60mg/kg x (current weight) _____ kg = ____ mg

FREQUENCY *(Choose one)*

☐ Weekly

☐ Other: _____

ADDITIONAL ORDERS

PRE-MEDICATION ORDERS

☐ Tylenol ☐ 500mg / ☐ 650mg PO

☐ Loratadine 10mg PO

☐ Pepcid 20mg ☐ PO / ☐ IVP

☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP

☐ Solumedrol ☐ 40mg / ☐ 125mg IVP

☐ Other: _____

NURSING

☑ Allow vial to come to room temperature prior to infusion

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications. pulmonary function testing confirming emphysema, documentation of nonsmoker status and continued optimal conventional treatment for emphysema (e.g., bronchodilators, supplemental oxygen if necessary). Diagnosis of congenital alpha1-antitrypsin deficiency confirmed by one of the following: Pi*ZZ, Pi*Z(null) or Pi*(null)(null) protein phenotypes (homozygous); or Other rare AAT disease-causing alleles associated with serum alpha1-antitrypsin (AAT) level < 11 µmol/L [e.g., Pi (Malton, Malton)]

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.