INTRAMED Plus
infusion services

ARALAST NP®

INFUSION & MEDICAL CENTER

1. Patient Name ______ **DOB** ______ **Patient Phone/Cell #** ______

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD-10 Code):

Primary Diagnosis: _____ Alpha$_1$-antitrypsin deficiency ICD-10 Code: E88.01

_____ Other: ______________________________ ICD-10 Code: _______

Allergies: ______________________________ (or attach list)

3. Clinical Information — Please fax with Infusion Order Form:

- Clinical Notes and Labs supporting primary diagnosis
  - Including: Serum AAT with genotype, PFTs, Lung imaging
  - Tried and failed therapies
- Medication List

Patient
Weight: _______ lbs.
Height _______ in.

Infusion Center — Lab Orders (Check Order for Infusion Center to Manage):

❏ Other ______________________________

ARALAST® NP [alpha1-proteinase inhibitor (human)] J Code: J0256

4. Drug Order:

❏ Infuse 60 mg/kg (+/- 10%) intravenously once weekly

(Where clinically appropriate, round to the nearest vial size)

_______ Refills (Recommend 51 Refills)

Pre-Medication Orders: ______________________________

No Pre-medications are recommended based on manufacturer guidelines.

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing our services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: ______________________ / ______________________ Date: ______________

Dispense as written | Substitution permitted

Printed Physician's Name with Credentials: ______________________ Phone #: ______________

FAX ALL INFORMATION CENTRAL FAX **803.999.1754**	**INFUSION CENTER LOCATIONS** BERKELEY CHARLESTON COLUMBIA GREENVILLE CENTRAL INTAKE PHONE 803.999.1760

DEC 2023