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: _____ Alpha1-antitrypsin deficiency ICD-10 Code: E88.01

_____ Other: _____ ICD-10 Code: _____

Allergies: _____ (or attach list)

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

Patient
Weight: _____ lbs.
Height _____ in.

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

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

❑ Other _____

- Lab Orders: _____ **Frequency:** ❑ Every injection ❑ 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 INTAKE PHONE
CENTRAL FAX **803.999.1754**	**803.999.1750**