INTRAMED Plus
infusion services

GLASSIA®

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 deficien y 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.

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

❑ Other: _____

GLASSIA® [alpha1-proteinase inhibitor (human)] J Code: J0257

5. Drug Order:

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

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

_____ Refills (ecommend 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**