PROLASTIN-C INFUSION ORDER (reslizumab)

Date: ____/____/_____

PATIENT INFORMATION

Patient Name:_____ DOB:___/____/____ Phone: _____

Height: _____ Weight _____ lbs / kg

Allergies: _____

Diagnosis: _____ ICD-10: _____

Alpha, Antitrypsin Date: _____/____/____ Result: _____

Labs to be drawn by: O Infusion Clinic O Referring Physician

Lab Orders: _____

PROLASTIN-C (ALPHA -PI) ORDERS

60 mg/kg (+/-10%) = _____mg once weekly
Start Date of Infusion: ___/___/___

PROVIDER INFORMATION

Provider's Name: _____ Signature: _____

Phone: _____ Fax: _____ Date: _____/_____/_____

Office Address: _____

Email Address: _____ Contact Person: _____

PLEASE SEND COPY (FRONT AND BACK) OF INSURANCE CARD

PHONE: 972-810-0990 | FAX: 972-810-0994