# RECOVERY ROOM IV THERAPY, LLP.

**Phone: 480-865-3322 Fax: 480-866-8189**

## Aralast NP Referral Order Form

### Patient Information

| | |
|---|---|
| Patient Name: | Patient DOB: |
| Patient Phone #: | Sex of Patient: |

### Provider Information

| | |
|---|---|
| Ordering Provider Name: | NPI # of Prescribing Provider: |
| Office Contact Name: | Office Phone #: |
| Office Contact Fax #: | Office Contact Email: |

## Aralast NP Medication Orders

Dosage
- _____ 60mg/kg IV once weekly
- _____ Other _____

Patient Weight: _____ Lbs or _____ Kg

Diagnosis with ICD 10 code **(REQUIRED)**
- Diagnosis: _____ Alpha$_1$-antitrypsin Deficiency ● ____Other _____
- ICD 10 code _____

| Pre-Medication | Refills |
|---|---|
| • Tylenol _____mg ● Benadryl _____ mg __IV or ___PO | • Zero _____ ● Treatments for 1 year _____ |
| • Solumedrol IV Push _____ mg ● Other _____ | • Other _____ |

### Required Documentation

○ **Insurance Cards (Front and Back)** ○ **Patient Demographics** ○ **Recent Progress Notes**
○ **Lab Results – CMP, CBC, IgA Antibodies**

**Special Instructions/Notes**

**Okay to substitute Aralast NP for Glassia, Prolastin-C, or Zemaira if Arlast NP is not available? ____ Yes or ___ No**

_____ _____

**Prescribing Provider Signature** **Date of Signature**