RECOVERY ROOM IV THERAPY, LLP.

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

Zemaira 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:

Zemaira 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 or Notess

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

_____ _____

Prescribing Provider Signature **Date of Signature**