

North Texas Specialty Pharmacy and Infusion Centers

3409 Worth St. Sammons Ste.710 Dallas, TX 75246 (214) 823-2533 FAX (214) 887-0436 www.NTISP.org

Prolastin® (Alpha1-Proteinase Inhibitor) Enrollment Form

Patient Information

Last Name		First Name	MI
Street Address	City	State	Zip Code
Phone (daytime)	Phone (cell)	Date of Birth	Sex

Primary Insurance Information Secondary Insurance Information Pharmacy Insurance Card

Insurance Name		Insurance Name	Insurance Name	
Cardholder Name	SSN	Cardholder Name	SSN	Member ID
Group / Policy Number	Group / Policy Number	BIN Number	Group Number	

Physician Information

Physician Name			Contact Person
Street Address	City	State	Zip Code
Physician DEA Number	Phone Number	Fax Number	

Statement of Medical Necessity

273.4 Alpha-1 Antitrypsin Deficiency 492.8 Panacinar Emphysema (date diagnosed) _____
 Other: ICD-9 Code: _____ Description: _____ (date diagnosed) _____

Pertinent Medical History

Patient Height: _____ Weight: _____ Allergies _____
Last dose of Prolastin date (If Applicable): _____
Phenotype: _____ Please attach copy of Results Alpha 1 Level: _____ (Please attach copy of Results)
Chest X-Ray (Attach copy of diagnostic Report) FEV1: _____
History and Physical Summary: _____

Intravenous Access Implanted Port PICC Line Central Line Peripheral IV each infusion
Flush Protocol Normal Saline 5-10 ml before and after each infusion
 Heparin Flush 5ml after each infusion as needed to maintain Venous Access
Initial LFT normal: No Yes History of CHF: No Yes Administer Hep B vaccine: No Yes

Prescription Orders

Prolastin® (Alpha1 – Proteinase Inhibitor) (Quantity: _____ mg per kg +/- 10%) Expected Length of Therapy _____
 Provide infusion supplies as necessary for administration of Prolastin. Anticipated start date _____
Reconstitute just prior to infusion with 40ml SWI and pool into Empty IV Bag for infusion as directed below.
Sig: Infuse _____mg over _____ minutes every _____ weeks Prolastin Refills: _____
 EpiPen per Package insert as needed EpiPen Refills: _____
Allergies: _____
Other meds: Other Med Orders: _____ Other Meds Refills: _____

Physician's signature _____

Date _____

Fax completed from to (214) 887-0436.

Insurance / Clearance questions call (214) 276-5642 or e-mail mike.ellis@ntisp.org. Pharmacy / Clinical questions call (214) 276-5623.

Include the following documents when faxing the enrollment form: pt's insurance card (s) front & back, Pharmacy Benefit Card, lab work, letter of medical necessity and any other documentation supporting the use of Prolastin.

Updated 06/30/2010

Patient's Preferred Infusion Center Location: Downtown Dallas NorthPark