

Prolastin-C Referral Order Form



WWW.PACEINFUSION.COM

PH: 330-625-4900

F: 330-685-9355

☐ New Referral ☐ Restart ☐ Medication/ Order Change
(New Order Required) ☐ Benefits Verification Only ☐ D/C Infusions
*indicate name of drug(s)

PACE Healthcare can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

PATIENT INFORMATION

Name: _____

DOB: _____ SS# _____

Phone # _____

Email: _____

PHYSICIAN INFORMATION

Referring Physician: _____

Practice Address: _____

Office Contact: _____

Contact Phone # _____ Contact Fax # _____

NPI / TIN: _____

PROLASTIN-C MEDICATION ORDERS

Dose: _____

Frequency: ☐ weekly

Patient Weight: _____ kg

☐ other _____

INDICATION/DIAGNOSIS

☐ Alpha -1- proteinase inhibitor deficiency

☐ Other _____

NOTES (ADDITIONAL INFO)

*ICD-10 _____ required

Referring Physician's Signature

Date

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report
(w/in past 6 months)
☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

☐ IgA antibodies

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY