ZEMAIRA (alpha-proteinase inhibitor) Referral Order Form

PACE HEALTHCARE LLC

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: _____ _____

ZEMAIRA MEDICATION ORDERS

Dose: _____ Frequency: ☐ weekly

Patient Weight: _____ kg ☐ other _____

INDICATION/DIAGNOSIS

☐ Alpha -1- proteinase inhibitor deficiency
☐ Other _____

***ICD-10 _____ required**

_____ _____
Referring Physician's Signature Date

NOTES (ADDITIONAL INFO)

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