

PROLASTIN-C Prescription and Enrollment Form

Fax to 1-866-588-6940

Patient Information

Patient Name (Last, First) _____
Social Security # _____ - _____ - _____ Gender Male Female Date of Birth _____
Address _____ Apt _____ City _____ State _____ Zip _____
Home Phone _____ Cell / Other Phone _____

Please attach front and back copy of patient's insurance cards.

Medical Information

Diagnosis: Alpha₁ Antitrypsin Deficiency 273.4 Panacinar Emphysema 492.8 Other _____

AAT Phenotype: _____ FEV1 _____% predicted Serum AAT Level _____ mg/dL or _____ μM

Weight _____ lb *OR* _____ kg Allergies None *OR* Specify _____

Attach documentation of the following medical information:

History / Physical Summary Last Chest X-ray
Most Recent PFTs Including FEV1 AAT Phenotype or Genotype Lab Report

PROLASTIN-C Prescription/Orders

PROLASTIN-C (alpha, proteinase inhibitor, human) Number of Refills: _____ months *Dispense up to a 30 day supply*

Dosage: 60 mg/kg (+/- 10%) IV weekly *OR* Other dose/frequency _____

Rate: As tolerated by patient up to 0.08 mL/kg/min *OR* Other rate _____

Reconstitute as directed in package insert

Monitor patient including VS before, Q15 during and 5 minutes post infusion

Premedication / other orders: _____

EpiPen® 0.3 mg. Inject from autodevice, prn, for allergic reaction

Provide medical supplies, including syringes and needles, to safely administer prescribed medication

Intravenous Access & Flush Orders:

Peripheral IV line Normal saline: 3-5 mL before infusion & 3-5 mL after infusion *OR* Other: _____

Implanted Port/Central Line (each lumen) Normal saline: 5-10 mL before infusion & 5-10 mL after infusion

Heparin: 100 units/mL, 5 mL after infusion and _____ (frequency)

First Dose Location Preference(s): Home *OR* Medical facility (name, phone of preferred facility, if any): _____

First Dose in Home Orders:

Establish primary IV line with 250 mL of Normal Saline *OR* D5W compatible solution at KVO rate prior to infusion

Monitor patient including VS before, Q15 during and 30 minutes post infusion

Diphenhydramine 25-50 mg IV as directed for severe allergic reaction or anaphylaxis

Premedication/other orders: _____

Physician / Office Information

Physician Name (print) _____ Office Phone _____

Address _____ Suite _____ Office Fax _____

City _____ State _____ Zip _____

Office Contact Person _____ Phone _____ NPI# _____

By signing below, I certify that the therapy described above is medically necessary and that the information provided is accurate to the best of my knowledge. I also attest that I have obtained the patient's authorization to release the above information and such other personal information as may be necessary to PROLASTIN DIRECT, Centric Health Resources, and/or their agents. If the patient is 18 years old or younger, I attest that I have obtained permission from the patient's legal guardian.

Physician Signature _____ Date _____

Substitution Permitted

Dispense as Written

Fax completed form and documentation to 1-866-588-6940. To reach the PROLASTIN DIRECT team, call 1-800-305-7881.

Please see Important Safety Information about Prolastin-C on back.

Documentation Checklist

Please fax the following documentation to PROLASTIN DIRECT so that we can start the insurance authorization process on your patient's behalf.

1. Completed PROLASTIN-C Prescription and Enrollment Form
2. Front and back copy of patient's insurance cards
3. History / Physical Summary
4. Last Chest X-ray diagnostic report
5. Most recent Pulmonary Function Report including FEV1
6. AAT Lab Reports:
 - a) Serum AAT Level
 - b) AAT Phenotype or Genotype

* Note: If you have both genotype and phenotype results, you may provide both, but insurance plans usually only require one of the two.

Fax completed form and documentation to 1-866-588-6940. To reach the PROLASTIN DIRECT team, call 1-800-305-7881.

Important Safety Information

PROLASTIN-C, Alpha₁-Proteinase Inhibitor (Human) is indicated for chronic augmentation and maintenance therapy in adults with emphysema due to deficiency of alpha₁-proteinase inhibitor (alpha₁-antitrypsin deficiency). The effect of augmentation therapy with any alpha₁-proteinase inhibitor (alpha₁-PI) on pulmonary exacerbations and on the progression of emphysema in alpha₁-antitrypsin deficiency has not been demonstrated in randomized, controlled clinical trials.

PROLASTIN-C may contain trace amounts of IgA. Patients with known antibodies to IgA, which can be present in patients with selective or severe IgA deficiency, have a greater risk of developing potentially severe hypersensitivity and anaphylactic reactions. PROLASTIN-C is contraindicated in patients with antibodies against IgA.

The most common drug related adverse reactions during clinical trials in $\geq 1\%$ of subjects were chills, malaise, headache, rash, hot flush, and pruritus. The most serious adverse reaction observed during clinical studies with Prolastin-C was an abdominal and extremity rash in one subject.

PROLASTIN-C is made from human plasma. Products made from human plasma may carry a risk of transmitting infectious agents, e.g., viruses, and theoretically, the Creutzfeldt-Jakob disease (CJD) agent.

Please see accompanying PROLASTIN-C full Prescribing Information for complete prescribing details.