

**Aralast NP® (alpha-proteinase inhibitor) Referral Form**



www.biohealthic.com | info@biohealthic.com

**PATIENT INFORMATION**

Referral Status: New Referral Updated Order Order Renewal

DOB: Patient Name: Patient Phone:
Patient Address: Patient Email:
NKDA Allergies: Weight (lbs/kg): Height:
ICD-10 code (required): ICD-10 description: Last Treatment Date: Last 4 SSN:

**PROVIDER INFORMATION**

Referral Coordinator Name: Referral Coordinator Email:
Ordering Provider: Provider NPI:
Referring Practice Name: Phone: Fax:
Practice Address: City: State: Zip Code:

**NURSING**

[x] Infusion to be administered per BioHealth protocols.

**ARALAST NP THERAPY ADMINISTRATION**

60 mg/kg body weight intravenously once per week

**LABORATORY ORDERS**

[ ] CBC at each dose every
[ ] CMP at each dose every
[ ] CRP at each dose every
OTHER

**REQUIRED DOCUMENTATION**

- Patient Demographics
Insurance Card/Information
Progress Notes Supporting DX
Medication List and H&P

**PREMEDICATIONS**

[ ] acetaminophen (Tylenol) 500mg 650mg / 1000mg PO
[ ] cetirizine (Zyrtec) 10mg PO
loratadine (Claritin) 10mg PO
diphenhydramine (Benadryl) 25mg 50mg PO IV
methylprednisolone (Solu-Medrol) 40mg 125mg IV
hydrocortisone (Solu-Cortef) 100mg IV
Other:
Dose: Route:
Frequency:

\*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. \*\*Order is valid for one year unless otherwise noted\*\*

Provider Name (Print) Provider Signature Date

Have a Question? (786)460-6044
Fax Referral Form To: (786)219-3917
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