



Nevada Infusion
5401 Longley Lane, Suite 34, Reno, NV 89511
PH: 775-453-0667 | Fax: 775-470-8478

Glassia Order Form

Patient Name: _____ DOB: _____
Phone: _____ Address: _____
City: _____ State: _____ Zip: _____ Email: _____
Sex: _____ Height: _____ Weight: _____ Allergies: _____

DIAGNOSIS:

- ☐ Alpha1-1-antitrypsin deficiency ICD-10: E88.01
☐ Other: _____ ICD-10: _____

ORDER FOR GLASSIA (alpha 1-proteinase inhibitor):

- ☐ 60 mg/kg IV weekly x 1 year
☐ Other Dose: _____ Frequency: _____ x 1 year

PRE-MEDICATIONS:

- ☒ Acetaminophen 650mg PO
☒ Diphenhydramine 25mg PO or IV or Zyrtec 10 mg PO
☒ Hydrocortisone 100mg IV or Methylprednisolone 125mg IV
☒ Additional Pre-Medications: _____

MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

- ☒ Nevada Infusion Hypersensitivity Reaction Order Set
☐ Other: _____

ACCESS: Peripheral IV, Port, Midline, or PICC line

FLUSHING: 10 mls NS pre/post infusion OR Heparin 5ml for port – 100 units/ml

NURSING: Per Nevada Infusion

LABS ORDERS: _____ Fax results to: _____

PROVIDER INFORMATION:

Physician Name: _____ NPI: _____
Physician Signature: _____ Date: _____
Point of Contact: _____ Phone: _____ Email: _____

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

****Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. ****



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Please Include Required Documentation for Expedited Order Processing & Insurance Approval:

- ☐ Signed provider orders (page 1)
- ☐ Patient demographic and insurance information
- ☐ Patient's current medication list
- ☐ Supporting recent clinical notes and H&P (to support primary diagnosis)
- ☐ Supporting documentation to include past tried and/or failed therapies
- ☐ Include labs and/or test results to support diagnosis
- ☐ Other medical necessity documentation (please include): _____

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