

Alpha1 Proteinase Inhibitor, Human (Prolastin-C Liquid, Aralast NP, Glassia)

Provider Order Form rev. 4/10/2022

PATIENT INFORMATION

Referral Status (check one): ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____

NKDA ☐ Allergies: _____ Weight _____ Please specify: ☐ lbs ☐ kg Height: _____

Patient Status (check one): ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date: _____ Next Due Date: _____

ICD-10 code (required): _____ ICD-10 description: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION

NURSING

- ☐ Provide nursing care per AdaptIV Infusion Nursing Procedures, including reaction management and post-procedure observation

PRE-MEDICATION ORDERS

- ☐ 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: _____

SPECIAL INSTRUCTIONS

THERAPY ADMINISTRATION

Alpha1 proteinase inhibitor, human, please choose one:

- ☐ **(Prolastin-C Liquid)** intravenous infusion with 5-15-micron infusion filter
- Dose: ☐ 60mg/kg (+/- 10%) ☐ Other: _____
 - Frequency: ☐ IV weekly ☐ Other: _____
 - Rate: ☐ Administer up to 0.08ml/kg/min
☐ Other: _____
(No less than 15mins)

☐ Glassia

- Dose: ☐ 60 mg/kg ☐ Other: _____
- Frequency: ☐ IV weekly ☐ Other: _____
- Rate: ☐ Administer a rate not to exceed 0.2 mL/kg/min with 5 micron infusion filter
☐ Other: _____

☐ Aralast NP

- Dose: ☐ 60 mg/kg ☐ Other: _____
- Frequency: ☐ IV weekly ☐ Other: _____
- Rate: ☐ Administer at a rate not to exceed 0.2mL/kg/min
☐ Other: _____

- ☐ Flush with 0.9% sodium chloride at the completion of infusion

- ☐ Patient is required to stay for 30-minute observation

- ☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____

(If not indicated order will expire one year from date signed)

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Provider Name (Print)

Provider Signature

Date