

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



Office: 212-803-3339 Fax : 646-768-8600

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

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
Allergies:	Date of Referral:	

PHYSICIAN INFORMATION		
Physician Name*:	Practice Name:	
Address:	Office Contact*:	
Phone:	Fax:	Email (for updates):

REFERRAL STATUS		
<input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> Discontinuation Order		

<input type="checkbox"/> NURSING Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation NOTE: IVX Adverse Reaction Management Protocol available for review at www.thrivewellinfusion.com

LABORATORY ORDERS <input type="checkbox"/> CBC <input type="checkbox"/> at each dose <input type="checkbox"/> every _____ <input type="checkbox"/> CMP <input type="checkbox"/> at each dose <input type="checkbox"/> every _____ <input type="checkbox"/> Other: _____

PRE-MEDICATION ORDERS <input type="checkbox"/> acetaminophen (Tylenol) <input type="checkbox"/> 500mg / <input type="checkbox"/> 650mg / <input type="checkbox"/> 1000mg PO <input type="checkbox"/> cetirizine (Zyrtec) 10mg PO <input type="checkbox"/> loratadine (Claritin) 10mg PO <input type="checkbox"/> diphenhydramine (Benadryl) <input type="checkbox"/> 25mg / <input type="checkbox"/> 50mg <input type="checkbox"/> PO / <input type="checkbox"/> IV <input type="checkbox"/> methylprednisolone (Solu-Medrol) <input type="checkbox"/> 40mg / <input type="checkbox"/> 125mg IV Other: _____ Dose: _____ Route: _____ Frequency: _____

SPECIAL INSTRUCTIONS <div style="border: 1px solid black; height: 80px; width: 100%;"></div>
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THERAPY ADMINISTRATION Alpha1 proteinase inhibitor, human, please choose one: <input type="checkbox"/> (Prolastin-C Liquid) intravenous infusion with 5-15-micron infusion filter •Dose: <input type="checkbox"/> 60mg/kg (+/- 10%) <input type="checkbox"/> Other: _____ •Frequency: <input type="checkbox"/> IV weekly <input type="checkbox"/> Other: _____ •Rate: <input type="checkbox"/> Administer up to 0.08ml/kg/min <input type="checkbox"/> Other: _____ (No less than 15mins) <input type="checkbox"/> Glassia •Dose: <input type="checkbox"/> 60 mg/kg <input type="checkbox"/> Other: _____ •Frequency: <input type="checkbox"/> IV weekly <input type="checkbox"/> Other: _____ •Rate: <input type="checkbox"/> Administer a rate not to exceed 0.2 mL/kg/min with 5 micron infusion filter <input type="checkbox"/> Other: _____ <input type="checkbox"/> Aralast NP •Dose: <input type="checkbox"/> 60 mg/kg <input type="checkbox"/> Other: _____ •Frequency: <input type="checkbox"/> IV weekly <input type="checkbox"/> Other: _____ •Rate: <input type="checkbox"/> Administer at a rate not to exceed 0.2mL/kg/min <input type="checkbox"/> Other: _____ <input type="checkbox"/> Flush with 0.9% sodium chloride at the completion of infusion <input type="checkbox"/> Patient is required to stay for 30-minute observation post IV <input type="checkbox"/> Patient is NOT required to stay for observation time <input type="checkbox"/> Refills: <input type="checkbox"/> Zero / <input type="checkbox"/> for 12 months / <input type="checkbox"/> _____ (if not indicated order will expire one year from date signed)
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NOTES/ADDITIONAL COMMENTS: <div style="border: 1px solid black; height: 60px; width: 100%;"></div>
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ORDERING PROVIDER

Signature X Date _____

Provider _____ Phone _____ Fax _____