

Philadelphia/Center City
1528 Walnut Street
Suite 1205
Philadelphia, PA 19102



Philadelphia/King Of Prussia
216 Mall Blvd
Suite#1
King Of Prussia, PA, 19046

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

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
Allergies:	Date of Referral:	

PHYSICIAN INFORMATION

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

REFERRAL STATUS

☐ New Referral ☐ Referral Renewal ☐ Medication/Order Change ☐ Benefits Verification Only ☐ Discontinuation Order

☐ 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

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ Other: _____

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
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 post IV

☐ Patient is NOT required to stay for observation time

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____ (if not indicated order will expire one year from date signed)

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X Date _____

Provider _____ Phone _____ Fax _____