

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		

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 _____