Phone and Fax: 608-690-7210
Email: info@MySmartInfusion.com
www.MySmartInfusion.com

Glassia (Alpha1 Proteinase Inhibitor)
Infusion Order Form

Patient Information

Patient Name: _____DOB: _____ M ☐ F ☐

Allergies: _____

☐ New Treatment ☐ Continuing Treatment Last Treatment Date: _____ Next Due Date: _____

Diagnosis and ICD 10 Code (Required)

☐ Alpha-antitrypsin deficiency ICD 10 Code: E88.01 ☐ Other DX: _____ ICD 10 Code: _____

Required Tests (within 12 months & attach results)

PFT Results _____
AAT Level Results _____
Chest Xray Results _____

Required Labs (within 3 months & attach results)

CBC Results _____
CMP Results _____
Other: _____

Pre-Medication Orders

Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg ☐ PO
Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV
Methylprednisolone (Solu-Medrol) ☐ 125mg ☐ IV
Ondansetron (Zofran) ☐ 4mg ☐ 8mg ☐ PO ☐ IV
Other: _____ Route: _____
Dose: _____ Frequency: _____

Nursing

Provide nursing care per Smart Infusion Nursing Procedures, Including reaction management and post-procedure observation.

Glassia Medication Order

Patient Weight: _____ KG

Dosage

☐ 60mg/kg IV
☐ Other _____

Frequency

☐ IV weekly
☐ Other_____

Required Documents

☐ Patient Demographic Sheet
☐ H & P within the past 6 months
☐ Current Medication List
☐ Clinical and Progress Notes

Special Instructions / Notes

Provider Information

Provider Name: _____ Provider NPI: _____

Office Phone: _____ Office Fax: _____

Provider Signature: _____ Date: _____