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Alpha1-Proteinase Inhibitor Infusion Order

Patient Name: DOB: □Male □Female

Diagnosis (please provide ICD10 code):

□ Other:

□ NKDA □ Allergies:

□ New Therapy Order □ Continuation of Therapy Date of last dose:

Ordering Provider Name:

Provider NPI: Phone: Fax:

Practice Address: City: State: Zip Code:

Pre Medications:

□ Acetaminophen _____mg by □ PO
□ Cetirizine _____mg by □ PO
□ Diphenhydramine _____mg by □ PO/ □ IVP
□ Solu-Medrol _____mg by □ PO/ □ IVP
□ Solu-Cortef _____mg by □ PO/ □ IVP
□ Other:

Required Documentation:

□ Patient Demographics
□ Patient Insurance (med and pharm card copies, front and back)
□ Progress Notes/Labs supporting diagnosis
□Other:

Patient Height and Weight: Patient Height (cm): _____
Patient Weight (kg): _____

Alpha1-Proteinase Inhibitor Medication Order (Please select ONE):

□ **Aralast NP** (Administer up to 0.2mL/kg/min)
- Intravenous Dosing
  - □ 60mg/kg
  - □ Other: _____
- Frequency
  - □ Once weekly
  - □ Other: _____

□ **Glassia** (Administer up to 0.2mL/kg/min)
- Intravenous Dosing
  - □ 60mg/kg
  - □ Other: _____
- Frequency
  - □ Once weekly
  - □ Other: _____

□ **Prolastin-C** (Administer up to 0.8mL/kg/min)
- Intravenous Dosing
  - □ 60mg/kg (+/- 10%)
  - □ Other: _____
- Frequency
  - □ Once weekly
  - □ Other: _____

Additional Instructions/Notes:

Patient IV Access
□ PIV
□ Use patient's SL/DL PICC, flush per protocol
□ Access/deaccess patient's Port, flush per protocol
*Imaging results of proper placement required for PICC/Port

Ordering Provider:

Signature: _____ Date: _____

Provider: _____ Phone: _____ Fax: _____

Best Contact Person in Office: _____ Phone: _____

Locations:
□ *Skokie, IL*: 4711 Golf Rd, Ste 900. P: 847-324-6800. F: 224-251-7141
□ *Libertyville, IL*: 1900 Hollister Dr, Ste 210. P: 847-324-6800. F: 224-251-7141
□ *Houston, TX*: 8303 SW Freeway, Ste 111. P: 346-738-9600. F: 346-613-8400