ALPHA-1 PROTEINASE INHIBITOR PRESCRIBER ORDER FORM

Patient Name:	**Date of Birth:**	**Gender:**
Address:		

Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description: Alpha-1 antitrypsin deficiency | **ICD-10 Code:** E88.01

Alpha-1 Proteinase Inhibitor Prescription

Select Product:

☐ Aralast® NP
☐ Glassia®
☐ Zemaira®
☐ Prolastin-C

Acceptable allotment +/- 10% based on vial lot/batch

Refill as directed x 1 year.
Infuse 60 mg/kg IV once weekly over 15 to 30 minutes (as determined by prescribing information).

Ancillary Orders

Anaphylaxis Kit

Does patient require an anaphylaxis kit?
☐ Yes, with 1st dose ☐ Yes, with all doses

- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SubQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

Medication Orders

☐ Other: _____

IV Flush Orders

☐ Peripheral: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.
☐ Implanted Port: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use.
For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Lab Orders

☐ No labs ordered at this time.

☐ Other: _____

Skilled nurse to assess and administer and/or teach self-administration where appropriate via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.
If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name:		**Phone:**	**Fax:**
Address:		**NPI:**	
City, State:	**Zip:**	**Office Contact:**	

Fax completed form, insurance information, and clinical documentation to:

