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

Provider Order Form rev. 9/20/2021

IVX HEALTH

PATIENT INFORMATION

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight lbs/kg:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

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.ivxhealth.com/forms (version 09.07.2021)

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)

Provider Name (Print) **Provider Signature** **Date**

Email ivxintake@ivxhealth.com or fax this form, insurance card (both sides), demographics, recent H&P, labs, and supporting clinicals to:

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