medix infusion

Alpha$_1$-Proteinase Inhibitor Order Form

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: ________________________________ DOB: ____________ Phone: ____________________ Sex: M / F Ht: _____ Wt: _____ lbs / kg

Primary Language: ____________________ Allergies: ____

Patient Preferred Location: ___________________________________

DIAGNOSIS & CLINICAL INFORMATION

<ICD 10 CODE REQUIRED>

ICD 10 Code

☐ E88.01 Alpha-1-Antitrypsin Deficiency

Other: ___________________________________

Prescribing Information

Alpha$_1$-Proteinase Inhibitors are **contraindicated** in Immunoglobulin A (IgA) deficient patients with antibodies against IgA and those with a history of anaphylaxis or other severe systemic reaction to Alpha$_1$-PI products.

REQUIRED: **Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**

LAB RESULTS: **Testing to support diagnosis: Alpha-$_1$ antitrypsin (AAT) protein blood testing, genetic testing results, Pulmonary Function Tests, &/or CT scan.**

PRESCRIPTION

Pre-Medications

☐ Acetaminophen: 650 mg PO

☐ Cetirizine: 10 mg PO

☐ Diphenhydramine: 25mg PO

☐ Diphenhydramine: 25mg IVP

☐ Famotidine: 20 mg PO

☐ Methylprednisolone: 125 mg SIVP

Other: ___________________________

Alpha$_1$-Proteinase Inhibitor (Human)

Dose: **(SELECT ONE)**

☐ Glassia **IV:** Infuse _________ mg/kg (+/- 10%) over at least 30 minutes or at a maximum rate of 0.2 mL/kg/min

☐ Prolastin-C **IV:** Infuse _________ mg/kg (+/- 10%) over at least 30 minutes or at a maximum rate of 0.08 mL/kg/min

☐ Aralast NP **IV:** Infuse __________ mg/kg (+/- 10%) over at least 30 minutes or at a maximum rate of 0.2 mL/kg/min

Frequency: **(FILL IN)**

Every __________ week(s) for one year

Patient Weight: __________ lbs **or** __________ kg

In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reaction protocol.

Post Treatment Observations: The patient is observed for 30 minutes following the first infusion.

Comments: ____

PRESCRIBER INFORMATION

Prescriber Name: ____ ***Signature:*** ____

Date: ______________________ NPI #: ________________________________ Specialty: ______________________________________

Supervising Physician: ____ (If Applicable)

Address: ____ City: _____________________________ State: ___________ Zip:__________

Contact Name: _______________________ Phone: _______________ Fax: __________________ Email: _________________________________