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: _____

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

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 Alpha1-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)

Loading 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

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

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

Comments:

_____

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____