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

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.

Medication Order

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)

☐ 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

Lab Orders+

Requested Add'l Lab Orders:

_____

_____

_____

Lab Frequency: _____every _____weeks

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

Comments: _____

Required Clinical Documentation

***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.**

Is the patient on any other disease modifying therapy? ☐ Yes ☐ No

If yes, please note therapy and last dose:

_____

Referring Provider Information

Signature: _____Date: _____

Prescriber Name: _____NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

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

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