

Prolastin-C (alpha1proteinase inhibitor, human) Infusion Orders

Patient Name: _____ DOB: _____ Male Female
Diagnosis (please provide ICD10 code) _____
 NKDA Allergies: _____
 New Start Therapy Continuation of Therapy Date of last dose (if applicable): _____

Ordering Provider:

Provider NPI: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zip Code: _____

PREMEDICATIONS

- Acetaminophen 1000mg PO Solu-Medrol 125mg IVP
 Diphenhydramine 25mg PO Solu-Cortef 100mg IVP
 Cetirizine 10mg PO Diphenhydramine 25mg IVP

REQUIRED LABS

- Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (please attach)
 Most recent PFTs including FEV1, AAT Phenotype or Genotype Lab Report, AAT level, and most recent chest X Ray (please attach all)

PROLASTIN ORDERS

DOSING:

- Dosage: 60 mg/kg (+/- 10%) IV weekly
Rate: As tolerated by patient up to 0.08 mL/kg/min (in no less than 15 minutes) IV infusion using 15 micron in-line filter
Other: _____

FREQUENCY:

- Intravenous infusion every 1 week
Other: _____

REFILLS:

- _____
(if not indicated prescription will expire one year from date signed)

Sage Infusion Standing Orders:

- Provide treatment under Sage Infusion's Clinical Guidelines, Medication Safety Protocol, Emergency Guidelines, and Action Plan for Infusion Reactions.

Provider Name

Provider Signature

Date