

Prolastin-C (alpha1proteinase inhibitor, human) Infusion Orders

Patient Name:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Diagnosis (please provide ICD10 code)		
<input type="checkbox"/> NKDA Allergies:		
<input type="checkbox"/> New Start Therapy	<input type="checkbox"/> Continuation of Therapy	Date of last dose (if applicable):

Ordering Provider:

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

PREMEDICATIONS

- | | |
|--|---|
| <input type="checkbox"/> Acetaminophen 1000mg PO | <input type="checkbox"/> Solu-Medrol 125mg IVP |
| <input type="checkbox"/> Diphenhydramine 25mg PO | <input type="checkbox"/> Solu-Cortef 100mg IVP |
| <input type="checkbox"/> Cetirizine 10mg PO | <input type="checkbox"/> 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)

Noble Infusion Standing Orders:

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

Provider Name

Provider Signature

Date