NobleInfusion

Fax: (386) 957 - 9400 I Online: www.nobleinfusion.com

GLASSIA 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
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ 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)

GLASSIA ORDERS

DOSING:

☐ Dosage: 60 mg/kg IV weekly

Rate: As tolerated by patient up to 0.2 mL/kg/min (in no less than 15 minutes) IV infusion using 5 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