



General

Patient Name _____ DOB _____ Height _____ Weight _____ Phone # _____
Order Start Date _____ Order Expiration Date (max one year) _____
Allergies: _____

Guidelines for Ordering:

1. Send **FACE SHEET** and **H&P** or most recent chart note.
2. This medication is not indicated as therapy for lung disease in patients in whom severe alpha 1-proteinase inhibitor deficiency has not been established.
3. The product may contain trace amounts of IgA. Severe anaphylaxis may occur in patients with anti-IgA antibody. Use in IgA deficient patients with antibodies against IgA is contraindicated.
4. This medication is derived from pooled human plasma which results in a risk of transmitting infectious agents.
5. Providers should note patients with established COPD and inform them of the risk for exacerbation. Frequent monitoring is recommended.

DIAGNOSIS CODE:

E88.01 Alpha-1 Antitrypsin Deficiency

Nursing Orders

IV ACCESS: Place peripheral IV Access Implanted Port

If nurse to access implanted port please complete Port Access Order Set as well

- Vital Signs: baseline and every 30 minutes until discharge. Hold patient for 30 minutes post-infusion to observe/monitor for adverse reaction
- Use a sterile 15 micron in-line filter when administering infusion.

Medication Orders

PROLASTIN C LIQUID (Alpha 1- Proteinase Inhibitor [Human]) _____ mg/kg IV once weekly (minimum of 7 days apart) for _____ total doses.

**Pharmacy to calculate dose and rate. Rate not to exceed 0.08mL/kg/min.*

MANAGEMENT OF SIDE EFFECTS

If adverse reaction (Hypotensive Reaction of SBP drop 25mmHg, phlebitis/vein spasm, abdominal/leg cramps, nausea, diarrhea): Hold infusion x 30 mins, if symptoms improve resume infusion at half previous rate, if symptoms persist give 500ml IV sodium chloride 0.9% bolus and call provider. If afterhours call hospitalist.

IF ANAPHYLACTIC REACTION OCCURS

Stop infusion immediately, notify provider and/or Hospitalist on duty if afterhours, administer oxygen prn, administer Benadryl 50 mg IV or IM once STAT, administer Epinephrine (1:1000) 0.5mg IM once STAT, possible admission to emergency department for further evaluation/treatment.

<p>Patient Name:</p> <p>DOB:</p>



Ordering Facility/Provider Information

By signing below, I affirm the following:

I am responsible for the care of the patient identified on this form.

I hold an active, unrestricted license to practice medicine in _____ (*specify state*)

My physician license number is # _____ and I am acting within my scope of practice and authorized by law to order infusion of the medication described above for the patient identified on this form.

Provider Signature: _____	Date _____
Printed name: _____	Phone: _____
Fax: _____	

KVH Provider Co-signature: <i>*Required for all external orders</i>	
Provider Signature: _____	Date _____
Printed name: _____	

<i>Patient Name:</i>
<i>DOB:</i>