Fax: 832-895-4040
Phone: 832-895-5000
E-mail: intake@adaptivinfusion.com

adaptIV infusion

Alpha1 Proteinase Inhibitor, Human (Prolastin-C Liquid, Aralast NP, Glassia)

Provider Order Form rev. 4/10/2022

PATIENT INFORMATION

Referral Status *(check one):* ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____

NKDA ☐ Allergies: _____ Weight _____ *Please specify:* ☐ lbs ☐ kg Height: _____

Patient Status *(check one):* ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date: _____ Next Due Date: _____

ICD-10 code (required): _____ ICD-10 description: _____

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.

PRESCRIPTION

NURSING

☐ Provide nursing care per AdaptIV Infusion Nursing Procedures, including reaction management and post-procedure observation

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg | ☐ 650mg | ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg | ☐ 50mg | ☐ PO | ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg | ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

THERAPY ADMINISTRATION

Alpha1 proteinase inhibitor, human, please choose one:

☐ **(Prolastin-C Liquid)** intravenous infusion with 5-15-micron infusion filter
- Dose: ☐ 60mg/kg (+/- 10%) ☐ Other: _____
- Frequency: ☐ IV weekly ☐ Other: _____
- Rate: ☐ Administer up to 0.08ml/kg/min
  ☐ Other: _____
  (No less than 15mins)

☐ **Glassia**
- Dose: ☐ 60 mg/kg ☐ Other: _____
- Frequency: ☐ IV weekly ☐ Other: _____
- Rate: ☐ Administer a rate not to exceed 0.2 mL/kg/min with 5 micron infusion filter
  ☐ Other: _____

☐ **Aralast NP**
- Dose: ☐ 60 mg/kg ☐ Other: _____
- Frequency: ☐ IV weekly ☐ Other: _____
- Rate: ☐ Administer at a rate not to exceed 0.2mL/kg/min
  ☐ Other: _____

SPECIAL INSTRUCTIONS

☐ Flush with 0.9% sodium chloride at the completion of infusion
☐ Patient is required to stay for 30-minute observation
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(If not indicated order will expire one year from date signed)

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

_____ _____ _____
Provider Name (Print) *Provider Signature* *Date*

REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK