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

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every ______________
☐ CMP ☐ at each dose ☐ every ______________
☐ Other: ______________________

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: ______________

☐ 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)

SPECIAL INSTRUCTIONS

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