EXPECARE FAMILY CARE URGENT CARE OF TEXAS

# Alpha$_1$-Proteinase Inhibitor
## Order Form

**FAX TO: 817-472-7213**

## PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

**Patient Preferred Location:** _____

## <ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

**ICD 10 Code**

☐ E88.01 Alpha-1-Antitrypsin Deficiency

Other: _____

**Prescribing Information**

Alpha$_1$-Proteinase Inhibitors are **contraindicated** in Immunoglobulin A (IgA) deficient patients with antibodies against IgA and those with a history of anaphylaxis or other severe systemic reaction to Alpha1-PI products.

***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.**
***LAB RESULTS:*** **Testing to support diagnosis: Alpha-1 antitrypsin (AAT) protein blood testing, genetic testing results, Pulmonary Function Tests, &/or CT scan.**

## PRESCRIPTION

**Pre-Medications**

☐ Acetaminophen: 650 mg PO
☐ Cetirizine: 10 mg PO
☐ Diphenhydramine: 25mg PO
☐ Diphenhydramine: 25mg IVP
☐ Famotidine: 20 mg PO
☐ Methylprednisolone: 125 mg SIVP
Other: _____

**ALPHA$_1$-PROTEINASE INHIBITOR (Human)**

**Loading Dose (SELECT ONE)**

☐ Glassia IV: Infuse _____ mg/kg (+/- 10%) over at least 30 minutes or at a maximum rate of 0.2 mL/kg/min
☐ Prolastin-C IV: Infuse _____ mg/kg (+/- 10%) over at least 30 minutes or at a maximum rate of 0.08 mL/kg/min
☐ Aralast NP IV: Infuse _____ mg/kg (+/- 10%) over at least 30 minutes or at a maximum rate of 0.2 mL/kg/min

**Frequency (FILL IN)**

Every _____ week(s) for one year

**Patient Weight:** _____ lbs **or** _____ kg

**Is the patient on any other disease modifying therapy?** ☐ **Yes** ☐ **No**
**If yes, please note therapy and last dose:** _____

**Post Treatment Observations:** The patient is observed for 30 minutes following the first administration.

**Adverse Events:** In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol.

**Comments:**

_____

## PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____