St. Charles Health System Alpha-1 Proteinase Inhibitor (PROLASTIN-C)	Patient Name: Date of Birth: *Patient Identification*

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE

Treatment Start Date: _____ Allergies: _____
Weight: _____kg Height: _____ cm

REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety
1. FACE SHEET with complete INSURANCE information and patient CONTACT information
2. Recent VISIT NOTE to support treatment (if not available in Epic)
3. LAB RESULTS for any required prescreening (if not available in Epic)
4. DIAGNOSIS CODE _____
5. Patient NAME and DATE OF BIRTH on EVERY page faxed

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. Providers should note patients with established COPD and inform them of the risk for exacerbation. Frequent monitoring is recommended.

NURSING ORDERS:

1. VITAL SIGNS – Prior to infusion and every 30 minutes during infusion.
2. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.
3. Infuse at 0.08 mL/kg/minute, rate may be increased or decreased based on patient comfort. Maximum rate of 19.5 mL/min. Requires a 5 micron in-line filter.

MEDICATIONS:

☐ Alpha-1 proteinase inhibitor (PROLASTIN-C) 60 mg/kg IV
(Dose may vary by up to 10% based on manufacturer lot number, Pharmacist will round dose to nearest vial size and during order verification)
Interval: (must check one)

- ☐ Once
- ☐ Weekly x _____ doses

INFUSION MONITORING/REACTION:

Infusion Reaction. Acute Infusion and Hypersensitivity Medication Protocol will be used unless the provider selects the option below. If opting out, alternative orders must be included.
1. diphenhydramine 25 mg IV, AS NEEDED x1 for hypersensitivity reaction

2. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
3. methylprednisolone 125 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. sodium chloride 0.9% 1000 mL IV, 200 mL/hr, AS NEEDED x 1 dose for alteration in hemodynamic status
6. albuterol 2.5 mg/3 mL nebule, AS NEEDED x1 dose for hypersensitivity reaction

☐ Opting out of standard protocol. Alternative orders are attached, or deviations are documented:
_____

Patient will be treated at the following infusion location:

☑ St. Charles Outpatient Infusion Center
2500 NE Neff Road, Bend, OR 97701
Phone: (541) 706-5820 Fax: (541) 706-5825

By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form

ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION

Signature: _____ License #: _____ Date: _____

Print Name: _____ Phone: _____ Fax: _____

Plan will expire 1 year after signature date at which time a new order will need to be placed