

DEMOGRAPHICS

Patient Name: _____ Name: _____
Address: _____ Address: _____
City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____
DOB: ____/____/____ ☐ Male ☐ Female Phone: _____ Fax: _____
Phone: _____ License#: _____
SSN: _____ Ht: _____ Wt: _____ DEA#: _____ NPI: _____

PRESCRIBING PHYSICIAN

ALLERGIES / REACTIONS

PHYSICIAN ORDERS

☒ **PROLASTIN** (Alpha - Proteinase Inhibitor (Human) **QUANTITY:** 4 weeks **REFILLS:** _____

60 mg/kg x _____ kg (patient's weight) = TOTAL DOSE _____ MG IV once weekly

****Acceptable allotment +/- 10% based on vial lot/batch**

☐ **OTHER** **REFILLS:** _____

☒ **Anaphylaxis Kit per Pharmacy protocol**

TO BE ADMINISTERED BY THE HEALTH CARE PROVIDER PRN FOR PATIENTS RECEIVING IV MEDS IN THE HOME

Epinephrine Auto Injector 0.3mg/0.3ml IM – Repeat one time in 20 minutes if needed

IV / ACCESS / MAINTENANCE:

- ☐ PORT - Flush before & after medication with 10ml NS. Lock with Heparin 500units/5ml
☐ PICC - Flush before & after medication with 10ml NS. Lock with Heparin 50units/5ml
☐ PERIPHERAL - Flush before & after medication with 10ml NS. Discontinue IV after infusion

DIAGNOSIS:

☒ E88.01 Alpha-1 antitrypsin deficiency

Signature: _____

Date: _____