ALPHA-1 PROTEINASE INHIBITOR PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:

option care health™

Patient Name:			**Date of Birth:**	
Address:				
Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description: Alpha-1 antitrypsin deficiency | **ICD-10 Code:** E88.01

Alpha-1 Proteinase Inhibitor Prescription

Select Product:

- ☐ Aralast® NP
- ☐ Glassia®
- ☐ Zemaira®
- ☐ Prolastin-C

Refill as directed x 1 year.

Infuse 60 mg/kg IV once weekly over 15 to 30 minutes (as determined by prescribing information).

Ancillary Orders

Anaphylaxis Kit

→ If this is a 1st dose, would you like Option Care Health to provide an Anaphylaxis kit with the 1st dose?

☐ Yes - Please complete Anaphylaxis Physician Order (FR-PC-036) provided ☐ No

Medication Orders

☐ Other: _____

IV Flush Orders

☐ Peripheral: NS 2 to 3 mL pre-/post-use.

☐ Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Lab Orders

☐ No labs ordered at this time.

☐ Other: _____

Skilled nurse to assess and administer and/or teach self-administration where appropriate via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name:		**Phone:**	**Fax:**
Address:		**NPI:**	
City, State:	**Zip:**	**Office Contact:**	

