Palmetto Infusion Services

MRN:_____

Phone: 800-809-1265 **DOB:** _____

STANDARD PROLASTIN PLAN OF TREATMENT

(Re)Certification Period from _____ to _____

NOTE: Patient is ***ineligible*** to receive Benlysta if receiving antibiotic for active infectious process (due to the possibility of developing a super-infection related to its effect on the immune status), or if he/she has a suspected infection.

Patient's Name _____ HT: _____ WT: _____ Allergies: _____

Diagnosis:

- ☐ 273.4 Alpha-1 Antitrypsin Deficiency
- ☐ _____

Orders:

Obtain weight each visit. Vital signs baseline and at completion of infusion. Instruct patient/caregiver on medications, signs/symptoms of adverse reaction. Assess patient for response to therapy. Utilize existing central line for administration, or initiate a peripheral IV with each infusion, prn. Normal Saline Flush 3-10 ml before infusion, after primary drug has infused, Infuse Normal Saline 0.9% 20-50 ml to flush tubing/line followed by Heparin Lock 1 – 5 ml 100 unit/ml as needed per line type. Pump, tubing, and supplies needed to complete prescribed therapy.

If adverse drug reaction, implement the Standing Adverse Reaction Protocol.

Dose: Prolastin _____ mg/kg (+/- 10%) over _____ hours via pump

Frequency:

- ☐ Orders to be completed every ☐ 1 week ☐ 2 weeks ☐ 3 weeks ☐ 4 weeks
- ☐ Special Orders: _____

Other: Pharmacist to perform clinical drug monitoring

(no stamped signatures please)

Physician's Signature: _____ _____ Date: _____

(Dispense as written) (Substitution permitted)

Print Physician Name: _____

PLEASE FAX DEMOGRAPHICS AND INSURANCE INFORMATION TO 866-872-8920