

Phone: 800-809-1265

MRN: \_\_\_\_\_

DOB: \_\_\_\_\_

**STANDARD ZEMAIRA 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:** Zemaira \_\_\_\_\_ 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**