

# ALPHA1-PROTEINASE INHIBITOR (HUMAN) ORDER FORM

- Aralast   
  Glassia   
  Prolastin-C Liquid   
  Zemaira  
 **OK to change to a suggested biosimilar above based on insurance or availability**

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Mobile Number: \_\_\_\_\_ Patient Weight: \_\_\_\_\_  
 Allergies: \_\_\_\_\_

## DIAGNOSIS (Provider must specify)

- Emphysema due to severe hereditary deficiency of Alpha1-PI (alpha1-antitrypsin deficiency), ICD 10: E88.01  
 Other: \_\_\_\_\_

## PROVIDER INFORMATION

Provider Name (print name): \_\_\_\_\_ Provider NPI: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Email Address: \_\_\_\_\_

**Prerequisites to treatment** – ensure the following information is complete and attached with referral:

- Demographics   
  Labs and tests supporting diagnosis   
  Office/progress notes

## PRE-MEDICATION (Not typically indicated)

- Acetaminophen (Tylenol) 500 mg PO   
  Famotidine 20 mg IV   
  Methylprednisolone (Solu-Medrol) 125 mg IVP  
 Benadryl 25mg PO   
  Cetirizine (Zyrtec) 10 mg PO  
 Other: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

## MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Alpha1-Proteinase Inhibitor (Human)	<input type="checkbox"/> 60 mg/kg body weight intravenously once per week	<input type="checkbox"/> IV	<input type="checkbox"/> once per week

- New Start Therapy   
  Continuation of Therapy   
 Date of last dose (if applicable): \_\_\_\_\_

## LABS / SPECIAL INSTRUCTIONS