KAISER PERMANENTE®

Kaiser Permanente Washington Home Infusion (KPWAHI)
Alpha-1 Proteinase Inhibitor Prescription Referral Form
Phone: (206) 326-2990 **Fax Referral To: (206) 326-2139**

1 PATIENT INFORMATION

Patient Name: _____
Phone: _____
Address: _____
City:_____**State:**_____**Zip:**_____
MRN #: _____
DOB: _____
Drug Allergies:

2 PRESCRIBER INFORMATION

Prescriber's Name: _____
DEA#: _____**NPI:** _____
Clinic/Facility Name: _____
Address: _____
City: _____**State:** _____**ZIP:** _____
Phone: _____**Fax:** _____

3 CLINICAL INFORMATION

Diagnosis (ICD-10 code): _____
Previous Alpha-1 Therapy: □ Aralast NP □ Prolastin-C Powder □ Prolastin-C Liquid □ Zemaira □ Other:_____
Last Dose: _____grams or _____ mg/kg **Date of Last Dose:** _____
Frequency of infusion: _____

4 ALPHA-1 PROTEINASE INHIBITOR PRESCRIPTION INFORMATION

First Dose: □ No □ Yes **Weight:** _____kg **Date Recorded:**_____
Alpha-1 Proteinase Inhibitor Product: □ **Aralast NP (preferred)** □ **Prolastin-C Powder** Route: Intravenous
Dose in mg/kg: _____ □ +/- 10% □ + 20% / -10% □ Other:_____
Frequency: _____
Refills: □ 11 months □ Other ____
Infusion Access: □ PIV □ CVAD □ Other: _____
Patient's Current Home Care/Specialty Pharmacy: _____

Infusion Reaction Medications & Supplies

- ✓ **Hydrocortisone sodium succinate injectable 100 mg IV**
  Sig: Once PRN for hypersensitivity
- ✓ **Epinephrine Auto-Injector** □ 0.15mg □ 0.3mg **QTY**: 2
  Sig: Inject into lateral thigh muscle for severe allergic reaction. Seek medical attention after use.
- ✓ **Diphenhydramine injectable 25 mg IV**
  Sig: Once PRN, may repeat x1 for urticaria, pruritis, shortness of breath
- ✓ **Sodium Chloride 0.9% IV 250ml Bag**
  Sig: Once PRN for anaphylaxis
- ✓ **Sodium Chloride 0.9% IV Flush**: Flush 10 ml IV before/after medication administration or as needed for line maintenance

Labs /Special Instructions/Pre-Meds: _____
_____

Alpha-1 Proteinase Inhibitor Infusion Protocol:

- Infuse per manufacturer guidelines
- Monitor vital signs (Temp, BP, HR, RR) every 15 minutes x 4; then every 30 minutes x2; then every 60 minutes until completion of infusion
- First Infusion: Do not exceed an infusion rate of
  - Aralast NP = 0.2 mL/kg/min
  - Prolastin-C = 0.08 mL/kg/min
- Documentation must include:
  - Start and end time of infusion
  - All rate changes, vital signs, including initial and final set
  - Patient response
- Observe patient for signs of infusion rate-related adverse reactions:
  - Blood pressure changes, increased pulse rate
  - Fever, chills
  - Headache
  - Chest, back or hip pain
  - Dyspnea
  - Mild erythema

5 PHYSICIAN SIGNATURE REQUIRED

X		X	
SUBSTITUTION PERMITTED	(Date)	DISPENSE AS WRITTEN	(Date)

Members with Medicare Part B or D coverage are not required to use this form.