

# Alpha<sub>1</sub>- Proteinase Inhibitor (Aralast NP) Infusion Therapy Plan Orders

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Name: \_\_\_\_\_

Kaiser Permanente Member I.D. # \_\_\_\_\_

Date of Birth \_\_\_\_\_

### Instructions to Provider

Review orders and note any changes. All orders with  will be placed unless otherwise noted. Please fax completed order form to the infusion center where the patient will be receiving treatment (see fax numbers page 2). Lab orders are not included on this form – place orders via usual method. Lab monitoring is the responsibility of the ordering physician.

**Please complete all of the following:**

<b>Order Date:</b> _____  <b>Weight:</b> _____ kg	<b>Diagnosis:</b> ICD-10 code (REQUIRED): _____  ICD-10 description _____ _____
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### General Plan Communication

- Special instructions/notes: \_\_\_\_\_

### Provider Information

- Dose may vary +/- 10% based on the drug lot produced. The pharmacist will adjust the dose and volume based on the product received for the patient.

### Infusion Therapy

- Alpha<sub>1</sub>-proteinase inhibitor (Aralast NP) IV infusion**  
**Dose:** \_\_\_\_\_ mg/dose (+/- 10%) =  \_\_\_\_\_ 60 mg/kg x weight (kg)  
**Route:** Intravenous  
**Frequency:**  **once every week until discontinued**  
 \_\_\_\_\_

*Infusion Rate:* As tolerated by patient up to 0.2 mL/kg/min

*If infusion-related reaction:*

- STOP infusion immediately;
- Increase primary infusion to wide open rate;
- Administer PRN medications per hypersensitivity protocol;
- Notify MD

**Note any changes to above regimen:** \_\_\_\_\_

### Pre-Meds

- No routine pre-medications necessary.  
 Other: \_\_\_\_\_  
*Dose:* \_\_\_\_\_ *Route:* Oral *Frequency:* Once, 30 minutes prior to infusion

### IV Line Care

- 0.9% sodium chloride infusion 250 mL  
*Rate:* 30 mL/hr *Route:* Intravenous *Frequency:* Run continuously to keep vein open  
 Start peripheral IV if no central line
- heparin flush 100 unit/mL  
*Dose:* 500 units *Route:* Intracatheter *Frequency:* PRN for IV line care per Nursing Policy

### Infusion Reaction Meds

- albuterol (PROVENTIL) nebulizer solution 0.083%  
*Dose:* 2.5 mg *Route:* Nebulization *Frequency:* PRN for shortness of breath/wheezing
- diphenhydrAMINE (BENADRYL) injectable  
*Dose:* 25 mg *Route:* Intravenous  
*Frequency:* Once PRN, May repeat x1 for urticaria, pruritus, shortness of breath. May repeat in 15 minutes if symptoms not resolved.

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

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- EPINEPHrine (EpiPen) 0.3 mg/0.3 mL IM Auto-Injector  
*Dose: 0.3 mg    Route: Intramuscular    Frequency: Once PRN for anaphylaxis. Inject into lateral thigh and hold for 10 seconds. Massage the injected area. Use for patients weighing greater than 27.3 kg (60 lbs). Use amp and 1.5 inch needle for patients with BMI greater than 30. Notify physician if administered.*
- hydrocortisone sodium succinate (SOLU-CORTEF) injectable  
*Dose: 100 mg    Route: Intravenous    Frequency: Once PRN for hypersensitivity*

## Nursing Orders

- Discontinue IV line when therapy complete and patient stabilized.

## References

- [ARALAST NP Prescribing Information. Revised Sep 2017.](#)

## Kaiser Permanente Infusion Locations

### Bellevue Medical Center

11511 NE 10<sup>th</sup> St, Bellevue, WA 98004

Fax: 425-502-3512    Phone: 425-502-3510

### Capitol Hill Medical Center

201 16<sup>th</sup> Ave E, Seattle WA 98112

Fax: 206-326-2104    Phone: 206-326-3109

### Everett Medical Center

2930 Maple St, Everett, WA 98201

Fax: 425-261-1578    Phone: 425-261-1566

### Olympia Medical Center

700 Lily Road N.E., Olympia, WA 98506

Fax: 360-923-7106    Phone: 360-923-7164

### Riverfront Medical Center – Spokane

W 322 North River Drive, Spokane, WA 99201

Fax: 509-324-7168    Phone: 509-241-2073

### Silverdale Medical Center

10452 Silverdale Way NW, Silverdale, WA 98383

Fax: 360-307-7493    Phone: 360-307-7444

### Tacoma Medical Center

209 Martin Luther King Jr Way, Tacoma, WA 98405

Fax: 253-383-6262    Phone: 253-596-3666

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_