KAISER PERMANENTE®

Name: _____

Kaiser Permanente Member I.D. # _____

Date of Birth _____

# Alpha$_1$- Proteinase Inhibitor (Prolastin C)
## Infusion Therapy Plan Orders



**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:***

**Order Date**: _____

**Weight:** _____kg

**Diagnosis:**
ICD-10 code *(REQUIRED):* _____

ICD-10 description_____

_____

### 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$_1$-proteinase inhibitor (PROLASTIN C) IV infusion**
***Dose:*** _____ **mg/dose (+/- 10%) =** ☐ _____ **60 mg/kg x weight (kg)**
*Route:* Intravenous
*Frequency:* ☑ **once every week x 6 months**
☐ _____

*Infusion Rate:* As tolerated by patient up to 0.08 mL/kg/min

*If infusion-related reaction:*
1) STOP infusion immediately; 2) Increase primary infusion to wide open rate; 3) Administer PRN medications per hypersensitivity protocol; 4) 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:** _____

KAISER PERMANENTE®

# Alpha$_1$- Proteinase Inhibitor (Prolastin C)
## Infusion Therapy Plan Orders



Name: _____

Kaiser Permanente Member I.D. # _____

Date of Birth _____

☑ 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

- PROLASTIN-C Prescribing Information

## Kaiser Permanente Infusion Locations

**Bellevue Medical Center**
*11511 NE 10th St, Bellevue, WA 98004*
**Fax: 425-502-3512 Phone: 425-502-3510**

**Capitol Hill Medical Center**
*201 16th 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:** _____