Alpha$_1$-Proteinase Inhibitor Order Form

(Aralast, Glassia, Prolastin-C, Zemaira)

SOMC Cancer Center & Infusion
Ph: (740) 356-7490
Fx: (740) 356-7488

PATIENT & PRESCRIBER INFORMATION

Patient Name: _____ DOB: _____ Phone: (H) _____ (C) _____

Patient Address: _____

Ht.: _____ Wt.: _____ ☐lbs. ☐kg. Allergies: _____

Prescriber Name/Title: _____ Address: _____

Phone: _____ Fax: _____ Prescriber NPI #: _____

REQUIRED: **Most Recent H&P, clinical notes, & medication list are required unless the patient is established with SOMC. Supporting clinical notes should include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**

TESTS REQUIRED : Alpha$_1$-PI Serum Levels; Pulmonary Function

DIAGNOSIS, CLINICAL INFORMATION, & PRESCRIPTION

☒ **May substitute mandated or preferred biosimilar as necessary.**

☒ **Infusion rates will follow manufacturer recommendations.**

☒ **In the event of an adverse reaction, line maintenance/flushes, or O2 are required, the SOMC AIC established protocols will be utilized.**

☒ **Monitor for any adverse events post administration for at least 30 minutes or until clinically stable.**

Pre-Treatment Medications: (Check all that apply) **To be administered 30 minutes prior to each administration.**

☐Acetaminophen (Tylenol) 650 mg by mouth x 1 dose

☐25 mg / ☐ 50 mg Diphenhydramine (Benadryl) ☐ PO or ☐ IV x 1 dose

☐Methylprednisolone (Solumedrol) 100 mg IVP x 1 dose

☐Other (**Please Specify**) –_____

AND

Diagnosis (Check all that apply)

☐ Alpha$_1$ Antitrypsin Defienciency ☐ Panlobular Emphysema ☐ Emphysema, unspecified ☐ Centrilobular Emphysema ☐ Other Emphysema

Dose:

☒ **Alpha$_1$-Proteinase Inhibitor 60 mg/kg IV once weekly x 1 year (+/- 10% unless ordered)**

Product Desired

☐**Aralast**
☐**Glassia**
☐**Prolastin-C**
☐**Zemaira**
☐**Other** _____

Additional order(s)_____

PROVIDER:	DATE:	TIME:	SIGNATURE:

Southern Ohio Medical Center
Very Good things are happening here

ALPHA1PRO

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Next Review Date	04/29/26
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