



Conveniently Located in East Syracuse, Onondaga Hill & Auburn

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Prolastin-C Non-Oncology Treatment Order Set

1. Patient Name: _____

2. DOB: _____ Height (inches): _____ Weight (lbs): _____

3. Diagnosis:

E88.01 Alpha-1-antitrypsin deficiency

Other ICD-10 Code: _____ Diagnosis description: _____

HOACNY will obtain authorization for drug administration prior to scheduled infusion. If HOACNY is unable to obtain insurance authorization due to this medication not being in alignment with the insurance plan's medical policy, referring office will be notified and HOACNY will not be able to administer the medication.

4. Pre-medications:

Acetaminophen:

1000mg PO 500mg PO

Diphenhydramine:

25mg PO 50mg PO 25mg IV 50mg IV

Hydrocortisone: 100mg IVP

Other Pre-medication: _____

No Pre-medications indicated

5. Drug Order:

Prolastin-C *Ok to substitute with generic/biosimilar*

Dose: _____ Frequency: _____

Special Instructions: _____

New to Therapy

Continuing therapy: Last Dose Received _____ Next Dose Due _____

HOA of CNY is responsible to provide nursing care, safe drug handling & administration, post-infusion observation & management of drug hypersensitivity reactions per the HOACNY Infusion Policy & Procedure Guidelines. Any changes in condition or delayed adverse events that occur after leaving the infusion center are to be reported to the prescribing physician for evaluation & management. The prescribing physician is responsible for educating the patient of potential risks & complications associated with drug administration as well as drug specific monitoring parameters before proceeding with Non-Oncology Infusion Referral

6. Infusion Lab Requirements:

CBC & CMP within 30 days prior to infusion

Other: _____

No lab monitoring indicated

HOA of CNY WILL NOT DRAW LAB WORK REQUIRED FOR INFUSION ADMINISTRATION.

The prescribing physician is responsible for ordering, obtaining, reviewing all laboratory results & providing copy to HOACNY prior to infusion as ordered above.

7. Baseline Lab/Testing completed:

Alpha-1 antitrypsin (AAT) protein blood testing, date: _____ Genetic Testing, date: _____

PFTs, date: _____ CT results, date: _____ Other: _____

8. Patient Assistance & REMS Program Enrollment

Yes, patient has been enrolled in _____ program. (Provide Copy Enrollment Forms)

No, patient has not been enrolled in any programs.

Physician's Name: _____ Phone: _____

Physician's Signature: _____ Date: _____

(This drug administration order form is valid for 12 months)