Conveniently Located in East Syracuse, Onondaga Hill & Auburn
Main Office Phone 315-472-7504
Nurse Navigator Phone 315-506-2469
Main Fax 315-634-5168

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: _____

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.

7. **Physician's Name**: _____ **Phone:** _____
Physician's Signature: _____**Date:** _____

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