Infusion Solutions Inc.
Home Infusion & Specialty Pharmacy

P: (360) 933-4892
F: (360) 933-1197
www.infusionsolutionsinc.com

GLASSIA (alpha$_1$-proteinase inhibitor, human) ORDER FORM

PATIENT NAME:_____ DOB:_____ WT:_____ HT:_____

ALLERGIES:_____

DIAGNOSIS

HAS THE PATEINT PREVIOUSLY RECEIVED: GLASSIA (alpha$_1$-PI (human)) ☐NO ☐YES

BRAND:_____ LAST DOSE DATE:_____

DIAGNOSIS:_____ ICD 10 CODE(S):_____

MEDICATION ORDERS

DOSE/FREQUENCY:

☐ 60 mg/kg body (actual body weight) IV once weekly (NTE 0.2 mL/kg/min; use 5 micron in-line filter)
☐ Other: _____

Orders are valid for 1 year. For a shorter duration, indicate here:_____

STANDARD IV ORDERS

ANCILLARY ORDERS:

- Infusion Reaction Management per Infusion Solutions Protocol.
- Alteplase 2mg IV to declot central IV access per Infusion Solutions protocol as needed for occlusion.
- Flush with 0.9% NaCl and/or Heparin 10 u/ml or 100 u/ml per Infusion Solutions protocol.
- Lidocaine 1% - up to 0.2 ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio).

NURSING ORDERS:

- If no central IV access, RN to insert peripheral IV.
- Obtain weight before each dose
- Monitor vital signs (temp, HR, RR, BP) before therapy, and every 15-30 minutes or with each rate change.
- If an infusion reaction occurs, decrease rate AND monitor vital signs until symptoms subside. If the reaction persists or worsens, stop the infusion, initiate reaction protocol, and notify physician.
- Observe patient for 30 minutes after completion of therapy.

LABS

LAB ORDERS:

☐ CBC w/ diff ☐ CRP
☐ CMP ☐ Other: _____

LAB FREQUENCY:

☐ Every dose
☐ Other: _____

REQUIRED DOCUMENTATION

REQUIRED CLINICAL DOCUMENTS:

- IgA labs (CONTRAINDICATED if patients are IgA deficient with antibodies against IgA)

RECOMMENDED CLINICAL DOCUMENTS (provide if available):

- Baseline labs (CBC w/ diff, CMP)

SUPPORTING DOCUMENTS:

- Patient demographic and insurance information.
- Copy of front and back of insurance card if available.
- Patient's medication list.
- Supporting clinical notes, including past tried and/or failed therapies.

PROVIDER INFORMATION

PRESCRIBER SIGNATURE (substitution) | *PRESCRIBER SIGNATURE (dispense as written)*

PRINT NAME (FIRST AND LAST) | *DATE*