Outpatient Prolastin-C Infusion Order Set

Klickitat Valley Health
Phone: 509-773-1000 Fax: 509-773-3354

General

Patient Name _____ DOB _____ Height _____ Weight _____ Phone #_____

Order Start Date _____ Order Expiration Date _____

Allergies: _____

Guidelines for Ordering:

1. Send **FACE SHEET** and **H&P** or most recent chart note.
2. This medication is not indicated as therapy for lung disease in patients in whom severe alpha 1-proteinase inhibitor deficiency has not been established.
3. The product may contain trace amounts of IgA. Severe anaphylaxis may occur in patients with anti-IgA antibody. Use in IgA deficient patients with antibodies against IgA is contraindicated.
4. This medication is derived from pooled human plasma which results in a risk of transmitting infectious agents.
5. Providers should note patients with established COPD and inform them of the risk for exacerbation. Frequent monitoring is recommended.

DIAGNOSIS CODE:

☒ E88.01 Alpha-1 Antitrypsin Deficiency

Nursing Orders

☐ **IV ACCESS:** ☐ Place peripheral IV ☐ Access Implanted Port

If nurse to access implanted port please complete Port Access Order Set as well

☒ Vital Signs: baseline and every 30 minutes until discharge. Hold patient for 30 minutes post-infusion to observe/monitor for adverse reaction

☒ Use a sterile 15 micron in-line filter when administering infusion.

Medication Orders

☒ PROLASTIN C LIQUID (Alpha 1- Proteinase Inhibitor [Human]) 60mg/kg IV once weekly (minimum of 7 days apart) for _____ total doses.

**Pharmacy to calculate dose and rate. Rate not to exceed 0.08mL/kg/min.*

MANAGEMENT OF SIDE EFFECTS

☒ If adverse reaction (Hypotensive Reaction of SBP drop 25mmHg, phlebitis/vein spasm, abdominal/leg cramps, nausea, diarrhea): Hold infusion x 30 mins, if symptoms improve resume infusion at half previous rate, if symptoms persist give 500ml IV sodium chloride 0.9% bolus and call provider. If afterhours call hospitalist.

IF ANAPHYLACTIC REACTION OCCURS

☒ In the event of an adverse reaction, which can be characterized by unexpected physiological responses such as a notable decrease in blood pressure, irritation at the injection site, muscle cramps, gastrointestinal distress (nausea and diarrhea), or other concerning symptoms: Hold infusion x 30 mins, if symptoms improve resume infusion at half previous rate, if symptoms persist consider administering 500ml IV sodium chloride 0.9% bolus and call provider. If afterhours call hospitalist.

OUTPATIENT NURSE- PLACE STICKER HERE

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Ordering Facility/Provider Information

By signing below, I affirm the following:

I am responsible for the care of the patent identified on this form.

I hold an active, unrestricted license to practice medicine in _____ *(specify state)*

My physician license number is # _____ and I am acting within my scope of practice and authorized by law to order infusion of the medication described above for the patient identified on this form.

Provider Signature: _____ **Date _____**

Printed name: _____ **Phone: _____** **Fax: _____**

KVH Provider Co-signature:

**Required for all external orders*

Provider Signature: _____ **Date _____**

Printed name: _____

OUTPATIENT NURSE- PLACE STICKER HERE