

PROLASTIN-C LIQUID Prescription and Enrollment Forms/SMN

With Fax Include: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes.

Order Date: ___/___/___

Referral Status: New Referral Dose or Frequency Change Renewal

Patient Name: _____

Primary Insurance: _____

Date of Birth: ___/___/___

Member ID: _____

Weight: ___ kg Height: ___ cm

Secondary Insurance: _____

Allergies _____

Member ID: _____

NKA

Authorization number _____

Last four digits of Social Security # _____ Gender Male Female

Address _____ Apt _____ City _____ State _____ Zip _____

Home Phone _____ Best time of day to reach patient: _____

Cell Phone _____ Email address _____

Please attach front and back copy of patient's insurance card

Medical Information

ICD-10 Diagnosis: Alpha-Antitrypsin Deficiency E86.01 Pan lobular Emphysema J43.1

Other _____

• AAT Phenotype _____ FEV ___ % predicted

• DLC ___ % predicted

• Serum AAT level ___ mg/dl ___ uM

• Weight _____ Lbs. **OR** _____ kg

*Attach Documentation of the following information:

1. History/Physical Summary 2. Last Chest X-ray or CT scan

3. Most recent PFT's Including 4. Hepatitis B Immunization

FEV, IgA levels 5. AAT Phenotype or Genotype Lab/Report

Steps to e-Prescribe PROLASTIN-C liquid

1. Fax in the PROLASTIN-C LIQUID Prescription and Enrollment Form/SMN

2. Prescribe PROLASTIN-CX LIQUID Intravenous Solution

3. Choose EVERSANA as the dispensing pharmacy (*EVERSANA is the exclusive dispensing pharmacy for PROLASTIN-C LIQUID)

PROLASTIN-C LIQUID Prescription orders

PROLASTIN-C LIQUID (alpha-proteinase inhibitor (human))

Number of Refills: 12 months *Dispense up to a 30-day supply* Other # _____

DOSAGE

60mg/kg (+/- 10%) IV weekly

Other dose/frequency _____

RATE

As tolerated by patient up to 0.08ml/kg/min

Other rate _____

Premedication/Other orders: _____

Establish primary IV line with 250-500 ml of Normal Saline

Establish primary IV line with _____ at KVO rate prior to infusion



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- EMLA or lidocaine 2.5%/Prilocaine 2.5%; Apply 2.5G over 20-25 cm of skin surface at least 1 hour prior to puncture
- Monitor patient including VS before, Q15 min during and 5 min post infusion
- THGH Standard of Care Protocol for IV Access/Line Management and Emergency Medications for Allergic Reactions.

Physician Name (print) _____ NPI# _____

Office Phone _____ Office Fax _____

Address: _____ Suite: _____

City _____ State _____ Zip _____

Office Contact Person _____ Phone _____

Office Contact Person Email _____

By signing below, I certify that the therapy described above is medically necessary and that the information provided is accurate to the best of my knowledge. I also attest that I have obtained the patient's authorization to release the above information as may be necessary to PROLASTIN DIRECT, EVERSANA, and/or their agents. If the patient is 18 years old or younger, I attest that I have obtained permission from the patient's legal guardian.

Physician Signature _____

Substitution Permitted

Dispense as Written

Fax completed form and documentation to 1-866-6940.

To reach the PROLASTIN DIRECT team, call 1-800-305-7881



PROLASTIC-C ORDER SET

The following Standard of Care Protocol has been approved for use in the Infusion Clinic at Trinity Health Grand Haven.

INTRAVENOUS ACCES AND LINE CARE PROTOCOL

| | |
|--------------------------|---|
| Type of Intravenous Line | <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Peripheral Access. <ul style="list-style-type: none"> <input checked="" type="checkbox"/> May leave Peripheral Access in place if consecutive Infusions are ordered (greater than or equal to daily) <input checked="" type="checkbox"/> PICC Line <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Discontinue PICC Line at the end of Infusion Therapy <input checked="" type="checkbox"/> Implanted Port <ul style="list-style-type: none"> <input checked="" type="checkbox"/> De-access Port if Infusions are less than or equal to weekly. De-access port at end of Infusion Therapy <input checked="" type="checkbox"/> Midline Catheter <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Discontinue Midline at the end of Infusion Therapy <input checked="" type="checkbox"/> Central Line (Non-tunneled) <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Discontinue Central Line at the end of Infusion Therapy |
| Line Care | <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Peripheral Access: Scrub the positive pressure injection cap(s) with alcohol for 30 seconds prior to accessing the line. <input checked="" type="checkbox"/> All other Access types: Scrub the positive pressure injection cap(s) with chlorhexidine for 15 seconds prior to accessing the line. If allergic to chlorhexidine, use betadine scrub for 30 seconds prior to accessing line. <input checked="" type="checkbox"/> All Access types: Change dressing every 7 days and PRN if soiled or non-occlusive <input checked="" type="checkbox"/> Biopatch to all Access types except Peripheral Access <input checked="" type="checkbox"/> If Implanted Port, change Huber needle with dressing change every 7 days. |
| Line Flushing | <p>Flushing protocol</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Peripheral Access flush with 3mL of 0.9% sodium chloride <i>before</i> and <i>after</i> each medication administration <input checked="" type="checkbox"/> All other access types: Flush with 10mL 0.9% sodium chloride <i>before</i> and <i>after</i> each medication administration or 20 mL 0.9% sodium chloride after blood draw <input checked="" type="checkbox"/> Flush capped lumens with 10mL 0.9% sodium chloride daily if lumen not in use. <input checked="" type="checkbox"/> Implanted Port: When de-accessing, flush with 10mL 0.9% sodium chloride and follow with 5mL of Heparin 100u/mL. |
| General Care | <p>For all Access types except Peripheral Access</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> May use Line for lab draws <input checked="" type="checkbox"/> Minimum of 5 mL of blood to be withdrawn and wasted prior to obtaining blood samples, administering medications or flushing port. <input checked="" type="checkbox"/> Only 10 mL size syringe to be used to withdraw samples or flush catheter. |
| Occlusion | <ul style="list-style-type: none"> <input checked="" type="checkbox"/> If unable to flush line, administer Alteplase (Cath-Flo) 2mg <input checked="" type="checkbox"/> If unable to flush line, notify Physician of occlusion <input checked="" type="checkbox"/> STAT portable chest x-ray after insertion Reason: Line Placement Confirmation |



PROLASTIC-C ORDER SET

| EMERGENCY MANAGEMENT OF ALLERGIC REACTIONS PROTOCOL | |
|--|--|
| Vital Signs | <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Vital Signs: if patient has suspected Allergic Reaction: Every 5 Minutes until stable then every 15 Minutes until symptoms resolve. <input checked="" type="checkbox"/> Pulse Oximetry: for suspected Allergic Reaction, initiate pulse oximetry monitoring until symptoms resolve. |
| Oxygen | <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Oxygen PRN adjust to maintain O2 Sat greater than 90% |
| Cardio-pulmonary | <ul style="list-style-type: none"> <input checked="" type="checkbox"/> ECG STAT if complaint of chest pain or difficulty breathing <input checked="" type="checkbox"/> Albuterol 2.5mg/3mL (0.003%) Nebulizer Treatment STAT PRN wheezing, bronchospasm, hypoxemia, dyspnea. Administer with oxygen. May repeat treatment Q10 Minutes for a total of 3 doses. <input checked="" type="checkbox"/> SVN |
| Medications | <ul style="list-style-type: none"> <input checked="" type="checkbox"/> 0.9% Sodium Chloride 500mL IVPB STAT PRN hypotensive management (SBP less than 90mmHg or MAP less than 60). Infuse over 30 Minutes. Notify Physician for further orders. <input checked="" type="checkbox"/> Acetaminophen (Tylenol) 650mg PO x1 dose PRN generalized pain, back pain, abdominal cramping, headache, or temperature greater than 100.5°F <input checked="" type="checkbox"/> Famotidine (Pepcid) 20mg IV PUSH STAT x1 Dose PRN Allergic Reaction Severity Grade 3. Administer over 2 Minutes. Notify Physician for further orders <input checked="" type="checkbox"/> Diphenhydramine (Benadryl) 50mg IV PUSH STAT x1 dose PRN Allergic Reaction Severity Grade 3. If patient has severe hypotension, administer after hypotensive episode is resolved. Use with caution in patient over 60 years of age or history of asthma. Notify Physician for further orders <input checked="" type="checkbox"/> Diphenhydramine (Benadryl) 25mg IV PUSH STAT x1 dose PRN Allergic Reaction Severity Grade 2. Use with caution in patient over 60 years of age or history of asthma. Notify Physician for further orders <input checked="" type="checkbox"/> Hydrocortisone 100mg IV PUSH STAT x1 PRN Allergic Reaction Severity Grade 3. Notify Physician for further orders <input checked="" type="checkbox"/> Epinephrine (EPI-PEN) 0.3mg/0.3mL IM STAT PRN Allergic Reaction Severity Grades 3-4 or Anaphylaxis. May repeat Q15 Minutes x2 doses. Notify Physician for further orders <p style="margin-top: 10px;"><i>Based on the CoFAR Grading System for Systemic Allergic Reactions Version 3.0</i></p> |

Per CMS survey and Certification group memo dated 8/11/2021, "the use of standing orders must be documented as an order in the patient's medical record and signed by the practitioner responsible for the care of the patient, but the timing of such documentation should not be a barrier to effective emergency response, timely and necessary care, or other patient safety advances.

