Princeton / Somerset New Jersey
49 Veronica Avenue
Suite 202
Somerset, NJ 08873

ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600

REJUVEINATE

Alpha1 Proteinase Inhibitor, Human (Prolastin-C Liquid, Aralast NP, Glassia) *Date:* _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
Allergies:	Date of Referral:	

PHYSICIAN INFORMATION

Physician Name*:	Practice Name:
Address:	Office Contact*:
Phone: Fax:	Email (for updates):

REFERRAL STATUS

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐Discontinuation Order

☐ NURSING

Provide nursing care per IVX Nursing Procedures, includingre-action management and post-procedure observation
NOTE: IVX Adverse Reaction Management Protocol available forreview at www.thrivewellinfusion.com

LABORATORY ORDERS

☐CBC ☐ at each dose ☐ every _____
☐CMP ☐ at each dose ☐ every _____
☐Other: _____

PRE-MEDICATION ORDERS

☐acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐1000mg PO
☐cetirizine (Zyrtec) 10mg PO
☐loratadine (Claritin) 10mg PO
☐diphenhydramine (Benadryl) ☐25mg / ☐50mg ☐ PO / ☐ IV
☐methylprednisolone (Solu-Medrol) ☐40mg / ☐125mg IV
Other:_____
Dose: _____ Route:_____
Frequency: _____

SPECIAL INSTRUCTIONS

THERAPY ADMINISTRATION

Alpha1 proteinase inhibitor, human, please choose one:

☐ **(Prolastin-C Liquid)** intravenous infusion with 5-15-micron infusion filter
•Dose: ☐60mg/kg (+/- 10%) ☐Other: _____
•Frequency: ☐IV weekly ☐Other:_____
•Rate: ☐Administer up to 0.08ml/kg/min
☐Other: _____
(No less than 15mins)

☐ **Glassia**
•Dose: ☐60 mg/kg ☐Other:_____
•Frequency: ☐IV weekly ☐Other: _____
•Rate ☐Administer a rate not to exceed 0.2 mL/kg/min with 5 micron infusion filter ☐Other:_____

☐ **Aralast NP**
•Dose: ☐60 mg/kg ☐Other:_____
•Frequency: ☐IV weekly ☐Other:_____
•Rate: ☐Administer at a rate not to exceed 0.2mL/kg/min
☐Other: _____

☐ Flush with 0.9% sodium chloride at the completion of infusion
☐ Patient is required to stay for 30-minute observation post IV
☐ Patient is NOT required to stay for observation time
☐ Refills: ☐ Zero / ☐ for 12 months /☐ _____ (if not indicated order will expire one year from date signed)

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____