Novella Infusion

Patient Name:
DOB:
Date of Last Infusion
Insurance:

Clinic Location:
Merrimack, NH ☐
Concord, NH ☐

Alpha$_1$-Proteinase Inhibitor (Prolastin-C®) Infusion Orders

Diagnosis (please provide ICD-10 code in space provided):

_____ alpha$_1$-antitrypsin deficiency (ICD-10) _____ Other: _____ (ICD-10)

Nursing:

- Bring solution to room temperature prior to infusion.
- For initial infusion, administer at a rate of 25 ml/hr for 15 minutes. If no adverse reaction noted, may increase to a maximum rate of 12 ml/kg/hr.
- Subsequent infusions may be administered at a maximum infusion rate of 12 ml/kg/hr or as tolerated.
- Record vital signs before and after infusion and prior to rate change, at least every 30 minutes.
- If infusion-related reaction occurs, stop infusion and follow Hypersensitivity Reaction Management Policy/Protocol as clinically indicated.

Administer Prolastin-C 60 mg/kg x current weight (_____ kg) = _____ mg
using a sterile, in-line filter (pore size 5 microns).

Dose may be rounded by up to 10% to nearest 1-gram increment per protocol. To PROHIBIT dose rounding, check here (☐).

Frequency (chose one):

☐ Weekly ☐ Other: _____

Provider name (print): _____ Date:_____

Provider signature: _____ Time: _____

Revised 6/5/19. Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.