

**C1 ESTERASE INHIBITOR [HUMAN] (CINRYZE®) PRESCRIBER ORDER FORM**

Patient Name:

Date of Birth:

Gender:

Address:

Phone:

Height:

☐ inches ☐ cm

Weight:

☐ lbs. ☐ kg**Clinical Information**

Primary Diagnosis Description: Defects in the complement system (hereditary angioedema)

ICD-10 Code: D84.1

**C1 Esterase Inhibitor [Human] (Cinryze®) Prescription****C1 Esterase Inhibitor [Human] (Cinryze®) 500 unit vial refill as directed x 1 year**

- ☐ Infuse 1000 units by slow IV injection at a rate of 1 mL/min every 3 to 4 days as directed for prophylaxis of HAE attacks.
- ☐ Infuse \_\_\_\_\_ units by slow IV injection at a rate of 1 mL/min every \_\_\_\_\_ days as directed for prophylaxis of HAE attacks.

Round dose to the nearest whole vial to avoid waste, where applicable.

Dispense \_\_\_\_\_ doses.

Keep \_\_\_\_\_ doses on-hand at all times.

**Ancillary Orders****Anaphylaxis Kit**

Does this patient require an anaphylaxis kit?

- ☐ Yes, with 1<sup>st</sup> dose    ☐ Yes, with all doses

**Medication Orders**

- ☐ Other: \_\_\_\_\_

**IV Flush Orders**

- ☐ Peripheral: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.
- ☐ Implanted Port: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use.  
For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Skilled nurse to assess and administer and/or teach self-administration, where appropriate, via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

*I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.*

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Prescriber Information**

Prescriber Name:

Phone:

Fax:

Address:

NPI:

City, State:

Zip:

Office Contact:

Fax completed form, insurance information, and clinical documentation to: **713-983-4647**

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