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 1st 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

Not valid for use for patients residing in Arizona, New York, and Wisconsin

