

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

Fax completed form, insurance information, and clinical documentation to: **(888) 582-7154**



Patient Name:	Date of Birth:			
Address:				
Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:	<input type="checkbox"/> lbs. <input type="checkbox"/> 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

If this is a 1st dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?

- Yes – please complete Anaphylaxis Physician Order (FR-PC-036) No

Medication Orders

- Other: _____

IV Flush Orders

- Peripheral: NS 2 to 3 mL pre-/post-use.
- Implanted Port: NS 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.

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:

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