(C1 esterase inhibitor)

CINRYZE Infusion Orders

Patient Name _____ DOB _____ Gender: ⬭ M ⬭ F

Phone_____

DIAGNOSIS: *Please provide IDC-10 Code*

☐ _____D84.1 Defects in the complement system (C1 esterase inhibitor [C1-INH] deficiency)
☐ _____(Other)

PRE-MEDICATION:

☐ Tylenol 1000mg PO
☐ Cetirizine 10mg PO
☐ Diphenhydramine 25mg PO
☐ _____Other

☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ _____Other

CINRYZE ORDERS:

DOSAGE/FREQUENCY:

⬬ **1,000u IV every 3-4 days**
⬬ ***Emergency Orders and Treatment per Specialty Infusion Center Anaphylaxis Policy***

PATIENT WEIGHT

_____LBS
_____KG

NOTES:

Nursing Orders

- Assess patient prior to each infusion
- Provide patient/caregiver education related to disease process, therapy, infection control, drug use, side effects and precautions, emergency plan
- Weigh patient every visit and record
- Monitor vital signs initially and throughout infusion per manufacturer recommendations
- Administer injection as ordered and as recommended by dose

ORDERING PROVIDER:

Signature _____ Printed Name: _____Date_____

Practice _____Phone_____ Fax _____

*****PLEASE FAX COMPLETED ORDER TO SPECIALTY INFUSION CENTER 231-600-7058*****

REV: 3/2023