*Vermont*
28 Park Ave
Suite #1A
Williston, VT 05495

ThrIVewell™ INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

**(C1 esterase inhibitor)**

# CINRYZE

Infusion orders

*Date:* _____

## PATIENT INFORMATION

| | | |
|---|---|---|
| Name: | DOB: | SEX: M ☐ F ☐ |
| ICD-10 code (required): | ICD-10 description: | |
| ☐NKDA Allergies: | | Weight lbs/kg: |

## REFERRAL STATUS

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐Discontinuation Order

## PHYSICIAN INFORMATION

| | |
|---|---|
| Referral Coordinator Name: | Referral Coordinator Email: |
| Ordering Provider: | Provider NPI: |
| Referring Practice Name: | Phone: Fax: |
| Practice Address: | City: State: Zip Code: |

### DIAGNOSIS D84.1

D84.1 - Defects in the complement system (C1 esterase inhibitor [C1-INH] deficiency)

☐ _____
☐ _____ _____

### PRE-MEDICATION

☐ Tylenol 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
☐ _____ *(other)*

☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ _____ *(other)*

### SPECIAL INSTRUCTIONS

### ACTEMRA ORDERS

**DOSE:**

1,000u IV every 3-4 days

Other_____

### PATIENT WEIGHT

_____ lbs.

_____ kg

### TOTAL DOSES:

☐ 1 yr _____ ☐ Other_____ ☐ Refill_____

Route: ☐ SQ ☐ IV

### NOTES/ADDITIONAL COMMENTS:

## ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____