

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



(C1 esterase inhibitor)

CINRYZE

Infusion orders

Date: _____

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> 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

<input type="checkbox"/> Tylenol 1000mg PO	<input type="checkbox"/> Solu-Medrol 125mg IVP
<input type="checkbox"/> Diphenhydramine 25mg PO	<input type="checkbox"/> Solu-Cortef 100mg IVP
<input type="checkbox"/> Cetirizine 10mg PO	<input type="checkbox"/> Diphenhydramine 25mg IVP
<input type="checkbox"/> _____ (other)	<input type="checkbox"/> _____ (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 _____