Fax: 614-929-7199/ Phone: 614-929-3349/ Email: Info@infuseoneohio.com

(C1 esterase inhibitor)

INFUSE ONE

CINRYZE infusion orders

Patient Name _____ DOB _____

Phone _____ M ☐ F ☐

DIAGNOSIS *Please provide ICD-10 code*

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

☐ _____ _____ *(other)*

PRE-MEDICATION

☐ Tylenol 1000mg PO

☐ Diphenhydramine 25mg PO

☐ Cetirizine 10mg PO

☐ _____ *(other)*

☐ Solu-Medrol 125mg IVP

☐ Solu-Cortef 100mg IVP

☐ Diphenhydramine 25mg IVP

☐ _____ *(other)*

CINRYZE ORDERS

DOSAGE

☑ 1,000u IV every 3-4 days

PATIENT WEIGHT

_____ lbs.

_____ kg

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

v1.6 Copyright 2018, Intellectual Property of WeInfuse , LLC