



(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:**

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

**CINRYZE ORDERS:**

**DOSAGE/FREQUENCY:**

- 1,000u IV every 3-4 days
- Emergency Orders and Treatment per Novello Infusion 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 NOVELLO INFUSION 231-600-7058\*\*\***