CURBSIDE INFUSION SERVICES

**Fax To:** (877) 428-1627
**Email To:** referrals@curbsideinfusion.com
**Office:** (877) 428-7248
Scheduling@curbsideinfusion.com Ext. 0
Billing@curbsideinfusion.com Ext 1

# CINRYZE (C1 esterase inhibitor) 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*