

# C1 ESTERASE INHIBITOR [HUMAN] (BERINERT®) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:



Patient Name:		Date of Birth:	
Address:			
Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg

## Clinical Information

Primary Diagnosis Description: Defects in the complement system (hereditary angioedema) ICD-10 Code: D84.1

## C1 Esterase Inhibitor [Human] (Berinert®) Prescription

C1 Esterase Inhibitor [Human] (Berinert®) 500 unit vial refill as directed x 1 year

Infuse \_\_\_\_\_ units by slow IV injection at a rate of 4 mL/min as needed for acute HAE attack.

Round dose to the nearest whole vial to avoid waste.

Dispense \_\_\_\_\_ doses.

Keep \_\_\_\_\_ doses on-hand at all times.

## Ancillary Orders

### Anaphylaxis Kit

If this is a 1<sup>st</sup> dose, would you like Option Care Health to provide an anaphylaxis kit with the 1<sup>st</sup> dose?

Yes – please complete Anaphylaxis Physician Order (FR-PC-036)  No

### Pre-Medication Orders

Other: \_\_\_\_\_

### IV Flush Orders

- Peripheral: NS 2 to 3 mL pre-/post-use.
- Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Skilled nurse to assess and administer and/or teach self-administration, where appropriate, via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

*I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.*

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Prescriber Information

Prescriber Name:	Phone:	Fax:
Address:	NPI:	
City, State:	Zip:	Office Contact:

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