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

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

YOUR INTELLIGENT HEALTH COMPANY. UBACARE	**Patient Name:**			**Date of Birth:**	
	Address:				
	Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs. ☐ 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 1st dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st 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:**	

