

# Hereditary Angioedema (HAE) Enrollment Form



Fax Referral To: 1-877-232-5455

Address: 500 Ala Moana Blvd., Ste 1-A Honolulu, HI 96813

Phone: 1-800-896-1464

## Six Simple Steps to Submitting a Referral

### 1 PATIENT INFORMATION (Complete or include demographic sheet)

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, ZIP Code: \_\_\_\_\_

Gender:  Male  Female

Preferred Contact Methods:  Phone (to primary # provided below)  Text (to cell # provided below)  Email (to email provided below)

Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

If **Minor**, Parent/Caregiver/Guardian Name (Last, First): \_\_\_\_\_

Relationship to minor: \_\_\_\_\_

Email: \_\_\_\_\_ Last Four of SSN: \_\_\_\_\_ Primary Language: \_\_\_\_\_

### 2 PRESCRIBER INFORMATION

Prescriber's Name: \_\_\_\_\_ State License #: \_\_\_\_\_

NPI #: \_\_\_\_\_ DEA #: \_\_\_\_\_ Group or Hospital: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, ZIP Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person: \_\_\_\_\_ Contact's Phone: \_\_\_\_\_

### 3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

### 4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: \_\_\_\_\_ Ship to:  Patient  Office  Other: \_\_\_\_\_

#### Diagnosis (ICD-10):

D84.1 Defects in the Complement System

Other Code: \_\_\_\_\_ Description: \_\_\_\_\_

#### Patient Clinical Information:

Allergies: \_\_\_\_\_

Weight: \_\_\_\_\_ lb/kg

Height: \_\_\_\_\_ in/cm

Check all that apply:

Patient is naive to HAE therapy

Patient is continuing HAE therapy of \_\_\_\_\_

Patient to infuse in ER/MDO

Home infusion allowed?

Other drugs used to treat HAE: \_\_\_\_\_

#### Nursing:

Specialty pharmacy to coordinate injection training/ home health infusion nurse visit necessary  Yes  No

Site of Care:  MD office  Infusion Clinic  Outpatient Health  Home Health

Injection training not necessary. Date training occurred: \_\_\_\_\_

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## Please Complete Patient and Prescriber Information

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_  
 Prescriber Name: \_\_\_\_\_ Prescriber Phone: \_\_\_\_\_

### 5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Berinert	500 Unit Vial	Infuse ___ units by slow IV injection at a rate of 4 mL per minute as needed for acute hereditary angioedema attack.	Quantity: Dispense ___ doses. Keep at least ___ doses on hand at all times. Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Cinryze	500 Unit Vial	Infuse ___ units (___ mL) by slow IV injection at a rate of 1 mL per minute (over 10 minutes) every ___ days.	Quantity: <input type="checkbox"/> 30-day supply <input type="checkbox"/> _____ Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Firazyr	30 mg/3 mL Syringe	Administer 30 mg (contents of one syringe) via subcutaneous injection in the abdominal area over at least 30 seconds, for an acute attack of HAE. If response is inadequate or symptoms recur, additional injections of 30 mg may be administered at 6-hour intervals with a maximum of 3 doses in 24 hours.	Quantity: Dispense ___ 30 mg doses. Keep at least three 30 mg doses on hand at all times (unless noted, otherwise ___ doses) Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Haegarda	<input type="checkbox"/> 2,000 IU Vial <input type="checkbox"/> 3,000 IU Vial	Administer ___ units (60IU/kg) every _____ days via subcutaneous injection	Quantity: <input type="checkbox"/> 30-day supply <input type="checkbox"/> Other: _____ Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Kalbitor	10 mg/mL Vial	Administer 30 mg (3 mL) subcutaneously in three 10 mg (1 mL) injections for an acute attack of HAE. If the attack persists, may repeat the dose one time within a 24-hour period.	Quantity: Dispense ___ 30 mg doses. Keep at least three 30 mg doses on hand at all times Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Ruconest	NA	All referrals must be sent through the HUB, Ruconest Solutions. Phone: 1-855-613-4HAE	Quantity: 0 Refills: 0
<input type="checkbox"/> Takhzyro	300 mg/mL Syringe	Administer 300 mg every ___ weeks via subcutaneous injection	Quantity: <input type="checkbox"/> 28-day supply <input type="checkbox"/> Other: _____ Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____

MEDICATION/SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS
Catheter <input type="checkbox"/> PIV <input type="checkbox"/> PORT <input type="checkbox"/> PICC	IV	Catheter Care/Flush – Only on drug admin days – SASH or PRN to maintain IV access and patency PIV – NS 5 mL (Heparin 10 units/mL 3-5mL if multiple days) PORT/PICC – NS 10 mL & Heparin 100 units/ml 3-5mL and/or 10 mL sterile saline to access port a cath
<input type="checkbox"/> Epinephrine **nursing requires**	<input type="checkbox"/> IM <input type="checkbox"/> SC	<input type="checkbox"/> Adult 1:1000, 0.3 mL (>30 kg/>66 lbs) <input type="checkbox"/> Peds 1:2000, 0.3 mL (15-30 kg/33-66 lbs) <input type="checkbox"/> Infant 0.1 mL/0.1 mL, 0.1 mL (7.5-15 kg/16.5-33 lbs) PRN severe allergic reaction – Call 911 May repeat in 5-15 minutes as needed

Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

### 6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

“Dispense As Written” / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute <b>Prescriber’s Signature:</b> _____ <b>Date:</b> _____	May Substitute / Product Selection Permitted / Substitution Permissible <b>Prescriber’s Signature:</b> _____ <b>Date:</b> _____
<b>CA, MA, NC &amp; PR:</b> Interchange is mandated unless Prescriber writes the words “No Substitution” _____ <b>ATTN: New York and Iowa providers,</b> please submit electronic prescription	

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient’s medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

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