Prescription & Enrollment Form

Hereditary Angioedema (HAE)

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❑ Do not contact patient, benefits check only

Four simple steps to submit your referral.

1 PATIENT INFORMATION

❑ New patient ❑ Current

Patient first name _____

Last name _____ Middle initial _____

Date of birth _____ ❑ Male ❑ Female Last 4 digits of SSN _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Parent/guardian (if applicable) _____

Cell phone _____ Other phone _____

E-mail address _____

Patient's primary language: ❑ English ❑ Other If other, please specify _____

Please attach copies of front and back of patient's insurance cards or complete information below.

Insurance company _____

Phone _____

Insured's name _____

Insured's employer _____

Relationship to patient _____

Identification # _____ Policy/group # _____

Prescription card: ❑ Yes ❑ No If yes, carrier _____

Policy # _____ Group # _____

Is patient eligible for Medicare? ❑ Yes ❑ No

Does patient have a secondary insurance? ❑ Yes ❑ No

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____

Prescriber's first name _____ Last name _____

Title _____

If NP or PA, under direction of Dr. _____

Office contact and title _____

Office contact email _____

Office/clinic/institution name _____

Clinic/hospital affiliation _____

Street address _____ Suite # _____

City _____ State _____ Zip _____

Phone _____ Fax _____

NPI # _____ License # _____

Deliver product to: ❑ Office ❑ Patient's home ❑ Clinic

Clinic location _____

3 CLINICAL INFORMATION

Primary ICD-10 code: ❑ D84.1 C1 esterase inhibitor [C1-INH] deficiency ❑ Other _____

Other drugs used to treat the disease _____

Weight _____ kg/lbs Date recorded _____

Height _____ cm/in Date recorded _____

❑ NKDA ❑ Known drug allergies _____

Adverse reactions with previous HAE treatments? _____

If so, what brand of HAE caused the reaction? _____

❑ Patient is naïve to HAE therapy ❑ Patient is continuing HAE therapy of _____

❑ Patient to infuse in ER/MDO ❑ Home infusion allowed

Concurrent meds _____

(May attach separate sheet if more space is required.)

4 PRESCRIBING INFORMATION

Medication	Strength/Formulation	Directions	Quantity/Refills
❑ Cinryze (C1 Esterase Inhibitor [human])	500 unit vial	Infuse _____ units by slow IV injection at a rate of 1 mL per minute every _____ days. Where clinically appropriate, please make dose divisible by 500 to avoid wastage.	Dispense: 1-month supply. Refill x 1 year unless noted otherwise ❑ Other _____
❑ Berinert (C1 Esterase Inhibitor [human])	500 unit vial	Infuse _____ units by slow IV injection at a rate of 4 mL per minute as needed for acute hereditary angioedema (HAE) attack. Where clinically appropriate, please make dose divisible by 500 to avoid wastage.	Dispense: _____ doses. Keep at least _____ doses on hand at all times. Refill x 1 year unless noted otherwise ❑ Other _____
Haegarda® (C1 Esterase Inhibitor Subcutaneous [human]) — Fax mandatory hub form found here: https://accredo.com/prescribers/referral_forms/haegarda.pdf to 866.415.2162			
Ruconest (C1 Esterase Inhibitor [recombinant]) — Fax mandatory hub form found here: https://accredo.com/prescribers/referral_forms/ruconest.pdf to 855.423.5757			
❑ Takhzyro (lanadelumab-flyo)	300 mg/2mL vial	❑ 300 mg by subcutaneous injection every two weeks ❑ 300 mg by subcutaneous injection every four weeks	Dispense: 1-month supply. Refill x 1 year unless noted otherwise ❑ Other _____
❑ icatibant	30 mg per 3 mL syringe	Administer 30 mg subcutaneously over at least 30 seconds for an acute attack of hereditary angioedema. If response is inadequate or symptoms recur, additional injections of 30 mg may be administered at intervals of at least 6 hours. Do not administer more than 3 doses in 24 hours.	Dispense: _____ 30 mg doses. Keep at least three 30 mg doses on hand at all times (unless noted otherwise _____ doses). Refill x 1 year unless noted otherwise ❑ Other _____
❑ Kalbitor (ecallantide)	10 mg/mL vial	Administer 30 mg (3 mL) subcutaneously in three 10 mg (1 mL) injections for an acute attack of hereditary angioedema. If the attack persists, may repeat the dose one time within a 24 hour period.	Dispense: Two 30 mg doses. Keep at least two 30 mg doses on hand at all times. Refill x 1 year unless noted otherwise ❑ Other _____
Kalbitor should only be administered by a healthcare professional with appropriate medical support to manage anaphylaxis. ❑ Kalbitor to be infused in physician's office or controlled medical setting and/or ❑ Home infusion allowed by a Kalbitor trained RN			
You must note the name of the brand product if brand is medically necessary for your patient _____			
Infusion Requirements (for Cinryze, Berinert and Kalbitor)			
Adverse reaction medications: *(keep on hand at all times)* Diphenhydramine 25 mg by mouth or IV (for Kalbitor only) for mild allergic reactions and 50 mg for moderate-severe. • <9 kg: Diphenhydramine 1 mg/kg up to max of 6.25 mg • 2–5 years old and >9 kg: Diphenhydramine 6.25 mg to 12.5 mg • 6–12 years old: Diphenhydramine 12.5 to 25 mg Epinephrine 0.3 mg auto-injector 2-pk for patient weighing greater than or equal to 30 kg. Administer intramuscularly as needed for severe anaphylactic reaction times one dose; may repeat one time. Epinephrine 0.15 mg auto-injector 2-pk, for patient weighing less than 30 kg. Administer intramuscularly as needed for severe anaphylactic reaction times one dose; may repeat one time. For Kalbitor only: Normal saline 250 mL intravenously for anaphylactic reaction and normal saline 3 mL flush before and after intravenous diphenydramine administration and as needed for line patency		Refill x 1 year unless noted otherwise ❑ Other _____
Flushing orders (for Cinryze and Berinert only): Normal saline 3 mL intravenous (peripheral line) or 10 mL intravenous (central line) before and after infusion, or as needed for line patency Heparin 100 units per mL 5 mL intravenous (central line) as needed for final flush			
Ancillary Supplies for all HAE products			
Dispense needles, syringes and ancillary supplies necessary to administer medication.			Refill x 1 year unless noted otherwise ❑ Other _____
Nursing Start of Care Orders for all HAE products			
Skilled nursing visit to provide patient education related to therapy, disease state, self and/or nurse administer of medication as prescribed. Visit frequency based on prescribed medication and dosage orders.			

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

By signing below, I certify that the above therapy is medically necessary. Prescriber's signature (sign below) (Physician attests this is his/her legal signature. **NO STAMPS**)

PHYSICIAN SIGNATURE REQUIRED

Date _____ Substitution allowed _____ Date _____ Dispense as written _____

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

Please fax completed form to your drug therapy team at 866.233.7151. To reach your team, call toll-free 866.820.4844.

You can now track shipments for all your Accredo patients. Go to https://prescribers.accredo.com and click "Help" to register.

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Prior Authorization Checklist
Hereditary Angioedema (HAE)

Providing Accredo with the documentation outlined in this checklist may increase the likelihood and speed of obtaining coverage for your patients with HAE. Coverage criteria many vary by payer.

Referral Form* (not required for electronic prescriptions or if using manufacturer hub form)	
	Completed HAE referral form (available at accredo.com)
	Copy of medical insurance card
	Copy of prescription benefits card

Clinical Documents	
	History of attacks
	C4 antigenic levels
	C1-Inhibitor functional (or mutation) levels
	Documentation of failure or contraindication to antifibrolytic agents
	OR
	17 alpha alkylated androgens

Prescriber Specialization	
	Allergist
	Immunologist
	Hematologist
	Rheumatologist
	Other

Fax completed form to 866.233.7151.

If you have any questions, please call your Accredo Provider Support Advocate, or call 866.820.4844.

*For referral forms visit accredo.com.

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