

For assistance, contact your pharmacy representative: _____ Phone: _____ (For providers only)

PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.

Note: This form is intended for prescriber use only, if faxed, the fax must come from MD office or hospital (may not be faxed by patient).



Hereditary Angioedema (HAE) Prescription/Pharmacy Intake Form

Pharmacy: Specialty360 HAE Team Pharmacy Fax: 866-889-1667 Pharmacy Phone: 877-865-9035 Date Needed: Ship To: [] Prescriber's Office [] Patient's Home [] Other:

PATIENT INFORMATION

Patient name: DOB: [] Male [] Female Address: City: State: Zip code: Phone # (Daytime): Phone # (Evening): E-mail Address: Case Manager: Insurance provider (Please include copy of front and back of card): ID #: Policy/Group #: Phone #: [] Patient is eligible for Medicare Name of Insured: Employer: Relationship to Patient: [] Self [] Other: Prescription Card: [] Yes [] No Carrier: Policy/Group #: Will there be access to anaphylactic medications and oxygen at the administration site?

CLINICAL ASSESSMENT - Please complete ALL sections to avoid delays in filling prescription.

[] Patient is new to therapy [] Patient is restarting therapy [] Patient is currently on therapy Start date: ICD-10 code: [] D84.1 [] Other (please specify) Date of Diagnosis: Other Diagnosis/Conditions: Concomitant Drugs for HAE: Concomitant Medications: Allergies: Locations of Angioedema: [] Abdomen [] Face [] Extremities [] Throat [] Other Current Weight: [] lb [] kg Date: Current Height: [] in [] cm Date: [] Other Therapies Tried & Failed (Please List): Flushing orders: [] Normal saline 3mL - 5mL intravenous (peripheral line) or 5mL - 10mL intravenous (central line) before and after infusion, or as needed for line patency [] Heparin 10units/mL (3mL - 5mL) use as a final flush for peripheral line [] Heparin 100units/mL (3mL - 5mL) use as a final flush for central line

OPTIONAL SPECIALTY PHARMACY NURSING ORDERS

Location of Skilled Nursing: [] Home [] Other: Skilled nursing visit as needed to provide patient education related to therapy, disease state, self and/or nurse administration of medication as prescribed. (Select 1 option below) [] Provide ongoing nursing visits for administration and education until patient/caregiver is independent with self infusion. [] Provide ongoing nursing visits for On Demand infusions, patient/caregiver unable or unwilling to learn self infusion. [] No nursing required; patient is independent with self infusion. Visit frequency (based on medication order and dosage order) and patient's/caregiver's ability to self-administer:

PRESCRIPTION INFORMATION

Table with 4 columns: Medication, Dose/Directions/Frequency, Quantity, Refills. Rows include Berinert 500 IU, Firazyr 30mg/3mL syringe, Haegarda, and Epinephrine injection (0.15 mg, 0.3 mg).

I authorize, by my signature below, the dispensing of appropriate needles and syringes, in a sufficient quantity, required for the administration of injectable products by patient or caregiver. Authorization for supplies runs concurrently with the number of refills or time frame specified for the drug.

PRESCRIBER INFORMATION

Prescriber's name: Practice/facility: Address: City: State: Zip code: Office contact: Phone: Fax: Email: Best time to call: Preferred method of contact: [] Email [] Phone [] Fax State license #: DEA #: NPI #: Medicaid UPIN #:

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" or your state specific required language after their signature. I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

Dispense as written Substitution permitted Date

*** THIS FORM IS NOT VALID IN THE STATE OF ALABAMA *** 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. The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. Drug names are the property of their respective owners. ©2022 AllianceRx Walgreens Pharmacy All rights reserved. 121222