

Patient Information	Clinical Information and Prescription
Patient Name: _____ Date of Birth: _____ Sex: M or F Caregiver: _____ Address: _____ City: _____ State: _____ Zip: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____ E-mail: _____ Please attach copy of front and back of patient's prescription ins. card(s) if applicable Insurance Company Name: _____ Insurance Company Phone: _____ Policy holder: _____ Policy holder Employer: _____ Relationship to Patient: _____ ID# _____ Group# _____ RxBIN: _____ RxPCN: _____ Copay Card: _____	Primary Diagnosis (ICD10): <input type="checkbox"/> ____ . ____ Description: _____ Secondary Diagnosis (ICD10): <input type="checkbox"/> ____ . ____ Description: _____ Height: _____ inches/ cm Weight: _____ lb/ kg Date of Measurement: ____/____/____ Allergies: _____ _____ Current Medications: _____ _____ _____
Prescriber Information	<input type="checkbox"/> Hereditary Angioedema Product: <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> Firazyr (icatibant) <input type="checkbox"/> Berinert* (877-236-4423 to order) <input type="checkbox"/> Ruconest* (855-613-4HAE to order) <input type="checkbox"/> Other: _____ </div> <div style="width: 45%;"> <input type="checkbox"/> Cinryze* (866-888-0660 to order) <input type="checkbox"/> Haegarda* (844-HAEGARDA to order) <input type="checkbox"/> Kalbitor* (866-888-0660 to order) </div> </div> Quantity: _____ Directions <input type="checkbox"/> Inj 30mg subcutaneously once. If response is inadequate or symptoms recur, may repeat dose at intervals of at least 6 hours. Max: 90 mg/24 hours <input type="checkbox"/> _____ _____
Practice/ Organization Name: _____ Prescriber Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone#: _____ Fax#: _____ DEA# _____ NPI# _____ License#: _____ Medicaid UPIN#: _____ Physician Specialty: _____ Prior Authorization Information: <input type="checkbox"/> Please fax PA forms <input type="checkbox"/> PA started <input type="checkbox"/> PA has been approved, auth #: _____ <input type="checkbox"/> Other: _____ Date Shipment Needed: _____ Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Prescriber <input type="checkbox"/> Other: _____ Shipment Address: _____ Attn: _____ City: _____ State: _____ Zip: _____ <i>If shipped to the prescriber's office, Prescriber accepts on behalf of patient for administration in office.</i> Current Nursing Agency or indicate if nursing needs set up: _____ _____	Refills Authorized: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 6 <input type="checkbox"/> 11 <input type="checkbox"/> Other: _____ Prescriber Signature: X _____ Date: ____/____/____ If physician requests Brand Name only, DAW MUST be HANDWRITTEN in the following space provided: <div style="border: 1px solid black; height: 40px; width: 100%; margin-top: 5px;"></div>

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