elixir
SPECIALTY PHARMACY

Hereditary Angioedema Enrollment Form

Phone: 877-437-9012 Fax: 877-309-0687

☐ New to Therapy
☐ Current Therapy

Patient Information

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:

Prescriber Information

Practice/ Organization Name: _____
Prescriber Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone#: _____ Fax#: _____
DEA# _____ NPI# _____
License#: _____ Medicaid UPIN#: _____
Physician Specialty: _____
Prior Authorization Information: ☐ Please fax PA forms ☐ PA started
☐ PA has been approved, auth #: _____
☐ Other: _____
Date Shipment Needed: _____
Ship to: ☐ **Patient** ☐ **Prescriber** ☐ **Other:** _____
Shipment Address: _____ Attn: _____
City: _____ State: _____ Zip: _____
If shipped to the prescriber's office,Prescriber accepts on behalf of patient for administration in office.
Current Nursing Agency or indicate if nursing needs set up: _____
_____

Clinical Information and Prescription

Primary Diagnosis (ICD10): ☐ _ _ _ . _ _ Description: _____
Secondary Diagnosis (ICD10): ☐ _ _ _ . _ _ Description: _____
Height: _____ ☐inches/☐cm Weight: _____ ☐lb/☐kg Date of Measurement: _____/_____/_____
Allergies: _____
_____
Current Medications:
_____
_____
_____

☐ **Hereditary Angioedema Product**:

- ☐ Firazyr (icatibant)
- ☐ Berinert* (877-236-4423 to order)
- ☐ Ruconest* (855-613-4HAE to order)
- ☐ Other: _____
- ☐ Cinryze* (866-888-0660 to order)
- ☐ Haegarda* (844-HAEGARDA to order)
- ☐ Kalbitor* (866-888-0660 to order)

Quantity: _____

Directions

☐ 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

☐ _____
_____

Refills Authorized: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 6 ☐ 11 ☐ Other: _____

Prescriber Signature: *X* _____ Date: _____/_____/_____

If physician requests Brand Name only,
DAW MUST be HANDWRITTEN in the following space provided: