elixir
SPECIALTY PHARMACY

Enzyme Replacement Therapy/Hereditary Angioedema Enrollment Form

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

☐ New to Therapy
☐ Current Therapy

Customer Information

Customer 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 customer's prescription insurance card(s) if applicable
Insurance Company Name: _____
Insurance Company Phone: _____
Policy holder: _____
Policy holder Employer: _____
Relationship to Customer: _____
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: _____
Has the patient tried and failed other products? ☐ Yes _____ ☐ No
Current Medications: _____
_____
Vascular Access: ☐ Peripheral IV ☐ Port-a-cath ☐ PIC ☐ Central line ☐ Other: _____
Administration by: ☐ Patient ☐ Caregiver ☐ Nursing Agency ☐ Other: _____
Agency nurse to visit home for injection: ☐ No ☐ Yes: Agency Name / Phone: _____
Date of First/Next Injection: ___/___/_____ Date of Last Injection: ___/___/_____
Pump: ☐ Need to rent from Elixir ☐ Patient owns a pump ☐ Other: _____
Pump Type: _____ Serial Number: _____ Other: _____

☐ Enzyme Replacement Product: ☐ Cerezyme ☐ Fabrazyme ☐ Elaprase
☐ Cerdelga ☐ Zavesca* (866-ACTELION to order) ☐ Elelyso* (855-ELELYSO to order) ☐ VPRIV
☐ Galafold* (833-AMICUSA to order) ☐ Other: _____
☐ HAE Product: ☐ Icatibant (Firazyr) ☐ Berinert (C1 inhibitor, human)
☐ Ruconest* (855-613-4HAE to order) ☐ Cinryze* (866-888-0660 to order) ☐ Haegarda* (844-HAEGARDA to order) ☐ Kalbitor* (866-888-0660 to order) ☐ Other: _____

Route of Administration: ☐ IV ☐ SC ☐ IM
Write "DAW" here if needed: ☐
Directions: _____
Infusion Rate: _____
Flush Protocol: _____

Ancillary medications:

Drug	Strength	Directions	Quantity	Refills
Diphenhydramine				
Acetaminophen				
EpiPen / EpiPen Jr.	0.3mg / 0.15mg	Inject IM/SQ into thigh, repeat after 5 to 20 minutes if needed for anaphylaxis		

Supplies requested: _____
_____
_____
Refills Authorized: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 6 mos ☐ 1 yr ☐ Other: _____
Prescriber Signature: *X*_____ Date: ____/____/____

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