Hereditary Angioedema (HAE) Enrollment Form



Fax Referral To: 1-877-232-5455 Address: 500 Ala Moana Blvd., Bldg 1 Honolulu, HI 96813

Phone: 1-808-254-2727 NCPDP: 1203417

Six	Simple Steps to Sul	omitting a Re	ferral
PATIENT INFORMATION (Complete	te or include demogra	aphic sheet)	
Patient Name:	•	•	Gender: 🗌 Male 🔲 Female
Address:		City, State, ZIP	Code:
Preferred Contact Methods: Phone (to primary			
Note: Carrier charges may apply. By providing			
-			tion(s), account, and health care. Standard data
rates apply. Message frequency varies. If una			
Primary Phone:			
Email: Parent/Caregiver/Legal Guardian Name (Las			Primary Language:
Falent/Calegiver/Legal Guardian Name (Las	si, Filsij		0 to patient.
2 PRESCRIBER INFORMATION			
—		State License	#:
NPI #: DEA #: G	Group or Hospital:		
Phone: Fax	Contact Person:		Contact's Phone:
3 INSURANCE INFORMATION Please	e fax copy of prescription	and insurance ca	ards with this form, if available (front and back)
Is the Patient Insured? ☐ Yes ☐ No Is the			
			Relationship to Patient:
Medical Insurance:	Telephone:	Policy IE	0: Group #:
Prescription Insurance:	· · ·	Prescription	Plan Telephone: RX PCN #:
Policy ID:	Group #:	RX BIN #:	RX PCN #:
Check box if patient is enrolled in manufac	cturer copay assistance I	f yes, please pro	vide ID#
_			
4 DIAGNOSIS AND CLINICAL INFORI	MATION		
Needs by Date:		t 🗌 Office 🗌 Ot	her:
<u> Diagnosis (ICD-10):</u>			
D84.1 Defects in the Complement Sys	stem		
Other Code: Description: _			
Patient Clinical Information:			
Allergies:	Weight: _	lb/kg	Height:in/cm
Check all that apply:			
Patient is naive to HAE therapy			
Patient is continuing HAE therapy of			
Patient to infuse in ER/MDO			
Home infusion allowed?			
Other drugs used to treat HAE:			
Nursing:			
Specialty pharmacy to coordinate injection tr	raining/home health infus	ion nurse visit na	ecessary 🗌 Yes 🗌 No
Site of Care: MD office Infusion Clinic			
Injection training not necessary. Date training			
Reason: MD office training patient Pt a	-	eferred by MD to	alternate trainer

Hereditary Angioedema (HAE) Enrollment Form Please Complete Patient and Prescriber Information

Patient Name: ___

Patient DOB:

Patient Phone:

Patient Address:_ Prescriber Name: Prescriber Phone:

MEDICATION STRENGTH DOSE& DIRECTIONS QUANTITY/REFILLS Berinert 500 Unit Vial Infuseunits by slow IV injection at a rate of 4 mL per minute as needed for acute hereditary angioedema attack. Quantity: Dispensedoses. Neep at leastdoses on hand at times. Refills::] 1 year] Other: angioedema attack. Cinnyze 500 Unit Vial Infuseunits (mL) by slow IV injection at a rate of 1 mL per minute (over 10 minutes) every days. Quantity: Dispense other: Refills::] 1 year] Other: Ountity:] 30 -day supply Berinzr 30 mg/3 mL Syringe Administer 30 mg (contents of one syringe) via subcutaneous injection in the abdominal area over at least 30 seconds, for an acute attack of HAE. If response is inadequate or symptoms recur, additional injections of 30 mg may be administered at 6-hour intervals with a maximum of 3 doses in 24 hours. Quantity: Dispense30 mg d Keep at least three 30 mg doses hand at all times (unless noted, otherwise	5 PRESCRIPTION INFORMATION							
□ Berinert 500 Unit Vial Infuse units by slow iV injection ara tate of malter angloedema attack. Keep at least doses on hand attitumes. □ Cinryze 500 Unit Vial Infuseunits () by slow IV injection at a rate of a rate of malter angloedema attack. Refills: □ 1 year □ Other: □ Cinryze 500 Unit Vial Infuseunits (mL) by slow IV injection at a rate of a rate			DOSE & DIRECTIONS	QUANTITY/REFILLS				
Infuseunits (mL) by slow IV injection at a rate of 1 mL per minute (over 10 minutes) everydays. Quantity:] 30-day supply .] 30-day supply .] 30-day supply .] 30-day supply .] 30-day supply .] 30 mg/3 mL Syringe Administer 30 mg (contents of one syringe) via subcutaneous injection in the abdominal area over at least 30 seconds, for an acute attack of HAE. If response is inadequate or symptoms recur, additional injections of 30 mg may be administered at 6-hour intervals with a maximum of 3 doses in 24 hours. Quantity: Dispense 30 mg doses hand at all times (unless noted, otherwise doses) Haegarda NA Please complete a Haegarda Connect Prescription & Service Request Form and fax it to Haegarda Connect at 1-866-415-2162 or CVS Specialty at 1-800-323-2445. Quantity: 0 Refills: 0 Mationary Please complete a Haegarda Connect Prescription & Service Request Form and fax it to Haegarda Connect at 1-866-415-2162 or CVS Specialty at 1-800-323-2445. Quantity: 0 Refills: 0 Mation 10 mg/mL Vial Administer 30 mg (3 mL) subcutaneously in three 10 mg (1 mL) injections for an acute attack of HAE. If the attack persists, may repeat the dose one time within a 24-hour period. Quantity: 0 Refills: 0 Mationest All referrals must be sent through the HUB, Ruconest Solutions. Phone: 1-855-613-4HAE Quantity: 0 Refills: 0 MEDICATION/SUPPLIES RoUTE OstF/STRENCTH/DIRECTIONS Quantity: 1 28-day supply aubcutaneous injection MEDICATION/SUPPLIES RoUTE Catheter Care/Flush - Only on drug admin days - SASH or PRN to main	Berinert	500 Unit Vial	4 mL per minute as needed for acute hereditary	Keep at least doses on hand at all times.				
□ Firazyr 30 mg/3 mL Syringe subcutaneous injection in the abdominal area over at least 30 seconds, for an acute attack of HAE. If response is inadequate or symptoms recur, additional injections of 30 mg may be administered at 6-hour intervals with a maximum of 3 doses in 24 hours. Quantity: Dispense30 mg d Keep at least three 30 mg doses hand at all times (unless noted, otherwisedoses) Refills: □ 1 year □ Other: □ Haegarda NA Please complete a Haegarda Connect Prescription & Service Request Form and fax it to Haegarda Connect at 1-866-415-2162 or CVS Specialty at 1-800-323-2445. Quantity: Dispense30 mg d Keep at least three 30 mg doses hand at all times Refills: 0 □ Kalbitor 10 mg/mL Vial Administer 30 mg (3 mL) subcutaneously in three 10 mg (1 mL) injections for an acute attack of HAE. If the attack persists, may repeat the dose one time within a 24-hour period. Quantity: Dispense30 mg d Keep at least three 30 mg doses hand at all times Refills: □ 1 year □ Other: □ Ruconest NA All referrals must be sent through the HUB, Ruconest Solutions. Phone: 1-855-613-4HAE Quantity: 0 Refills: 0 □ Takhzyro □ 150 mg/mL Syringe □ Administer 150 mg every weeks via subcutaneous injection Quantity: 0 Refills: 0 MEDICATION/SUPPLIES ROUTE Catheter Care/Flush - Only on drug admin days - SASH or PRN to maintain IV access patency □ PIV □ PORT IV PIV - NS 5 mL (Heparin 10 units/mL	Cinryze	500 Unit Vial	at a rate of 1 mL per minute (over 10 minutes) every days.	Quantity: 🗌 30-day supply				
Haegarda NA Prescription & Service Request Form and fax it to Haegarda Connect at 1-866-415-2162 or CVS Specialty at 1-800-323-2445. Refills: 0 Kalbitor 10 mg/mL Vial Administer 30 mg (3 mL) subcutaneously in three 10 mg (1 mL) injections for an acute attack of HAE. If the attack persists, may repeat the dose one time within a 24-hour period. Quantity: Dispense30 mg d Keep at least three 30 mg doses hand at all times Refills: 1 year	🗌 Firazyr	-	subcutaneous injection in the abdominal area over at least 30 seconds, for an acute attack of HAE. If response is inadequate or symptoms recur, additional injections of 30 mg may be administered at 6-hour intervals with a					
Kalbitor 10 mg/mL Vial three 10 mg (1 mL) injections for an acute attack of HAE. If the attack persists, may repeat the dose one time within a 24-hour period. Keep at least three 30 mg doses hand at all times Ruconest NA All referrals must be sent through the HUB, Ruconest Solutions. Phone: 1-855-613-4HAE Quantity: 0 Integration Integration All referrals must be sent through the HUB, Ruconest Solutions. Phone: 1-855-613-4HAE Quantity: 0 Integration Integration Administer 150 mg every weeks via Quantity: Integration Quantity: Integration Integration Integration Administer 150 mg every weeks via Quantity: Integration Quantity: Integration Integration Integration Integration Integration Quantity: Integration Quantity: Integration Integration Integration Integration Integration Quantity: Integration Quantity: Integration Integration Integration Integration Integration Integration Quantity: Integration Quantity: Integration Integration Integration Integration Integration Integration Quantity: Integration Quantity: Integration Integration Integration Integration Integr	Haegarda	NA	Prescription & Service Request Form and fax it to Haegarda Connect at 1-866-415-2162 or CVS					
Ruconest NA All referrals must be sent through the HUB, Ruconest Solutions. Phone: 1-855-613-4HAE Refills: 0 Takhzyro 150 mg/mL Administer 150 mg every weeks via Syringe Quantity: 28-day supply 300 mg/2 mL 300 mg/2 mL Administer 300 mg every weeks via subcutaneous injection Other: MEDICATION/SUPPLIES ROUTE DOSE/STRENGTH/DIRECTIONS Refills: 1 year Other: Catheter IV PIV - NS 5 mL (Heparin 10 units/mL 3-5 mL if multiple days) PORT/PICC - NS 10 mL & Heparin 100 units/mL 3-5 mL, and/or 10mL sterile saline to post for the saline to patency	Kalbitor	10 mg/mL Vial	three 10 mg (1 mL) injections for an acute attack of HAE. If the attack persists, may repeat the	Quantity: Dispense 30 mg doses. Keep at least three 30 mg doses on hand at all times Refills: 1 year Other:				
Takhzyro Syringe subcutaneous injection Other: 300 mg/2 mL Administer 300 mg every weeks via Refills: 1 year Syringe subcutaneous injection DOSE/STRENGTH/DIRECTIONS MEDICATION/SUPPLIES ROUTE Catheter Care/Flush – Only on drug admin days – SASH or PRN to maintain IV access Catheter IV PIV – NS 5 mL (Heparin 10 units/mL 3-5 mL if multiple days) PICC PORT/PICC – NS 10 mL & Heparin 100 units/mL 3-5 mL, and/or 10mL sterile saline to	Ruconest	NA						
Catheter Catheter Care/Flush – Only on drug admin days – SASH or PRN to maintain IV access patency PIV PORT IV PIV – NS 5 mL (Heparin 10 units/mL 3-5 mL if multiple days) PICC PORT/PICC – NS 10 mL & Heparin 100 units/mL 3-5 mL, and/or 10mL sterile saline to	-	Syringe 300 mg/2 mL Syringe	subcutaneous injection Administer 300 mg every weeks via subcutaneous injection	Cther: Refills: 1 year C Other:				
Catheter patency PIV PORT IV PIV – NS 5 mL (Heparin 10 units/mL 3-5 mL if multiple days) PICC PORT/PICC – NS 10 mL & Heparin 100 units/mL 3-5 mL, and/or 10mL sterile saline to	MEDICATION/SUPPLIES	ROUTE						
access port a cam		IV	patency					
Epinephrine IM **nursing requires** IM SC Infant 0.1 mL/0.1 mL, 0.1 mL (7.5-15 kg/16.5-33 lbs) PRN severe allergic reaction – Call 911 May repeat in 5-15 minutes as needed	**nursing requires**	sc	 Peds 1:2000, 0.3 mL (15-30 kg/33-66 lbs) Infant 0.1 mL/0.1 mL, 0.1 mL (7.5-15 kg/16.5-33 lbs) PRN severe allergic reaction – Call 911 					

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do DAW / May Not Substitute Prescriber's Signature:	Not Substitute / No Substitution / Date:	May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature:	Date:
CA. MA. NC & PR: Interchange is mandated unless Prescrib	er writes the words " No Substitution "	ATTN: New York and Iowa provide	ers. please submit electronic prescription

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

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