

Hereditary Angioedema (HAE) Enrollment Form



Fax Referral To: 1-855-297-1270

Phone: 1-888-280-1190

Address: 6020 Ave Roberto Sanchez Vilella Carolina, PR 00982

NCPDP: 4026325

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION (Complete or include demographic sheet)

Patient Name: _____ DOB: _____ Gender: ☐ Male ☐ Female

Address: _____ City, State, ZIP Code: _____

Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)

Note: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone: _____ Alternate Phone: _____

Email: _____ Last Four of SSN: _____ Primary Language: _____

Parent/Caregiver/Legal Guardian Name (Last, First): _____ Relationship to patient: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____

NPI #: _____ DEA #: _____ Group or Hospital: _____

Address: _____ City, State, ZIP Code: _____

Phone: _____ Fax: _____ Contact Person: _____ Contact's Phone: _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

Is the Patient Insured? ☐ Yes ☐ No Is the Patient enrolled or eligible for Medicare/Medicaid? ☐ Yes ☐ No

Policy Holder's Name: _____ Policy Holder's DOB: _____ Relationship to Patient: _____

Medical Insurance: _____ Telephone: _____ Policy ID: _____ Group #: _____

Prescription Insurance: _____ Prescription Plan Telephone: _____

Policy ID: _____ Group #: _____ RX BIN #: _____ RX PCN #: _____

☐ Check box if patient is enrolled in manufacturer copay assistance If yes, please provide ID# _____

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: ☐ Patient ☐ Office ☐ Other: _____

Diagnosis (ICD-10):

☐ D84.1 Defects in the Complement System

☐ 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 training/ home health infusion nurse visit necessary ☐ Yes ☐ No

Site of Care: ☐ MD office ☐ Infusion Clinic ☐ Outpatient Health ☐ Home Health

Injection training not necessary. Date training occurred: _____

Reason: ☐ MD office training patient ☐ Pt already independent ☐ Referred 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: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Berinert	500 Unit Vial	Infuse ____ units by slow IV injection at a rate of 4 mL per minute as needed for acute hereditary angioedema attack.	Quantity: Dispense ____ doses. Keep at least ____ doses on hand at all times. Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Cinryze	500 Unit Vial	Infuse ____ units (____ mL) by slow IV injection at a rate of 1 mL per minute (over 10 minutes) every ____ days.	Quantity: <input type="checkbox"/> 30-day supply <input type="checkbox"/> _____ Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Firazyr	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. Keep at least three 30 mg doses on hand at all times (unless noted, otherwise ____ doses) Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> 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
<input type="checkbox"/> 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: Dispense ____ 30 mg doses. Keep at least three 30 mg doses on hand at all times Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
<input type="checkbox"/> Ruconest	NA	All referrals must be sent through the HUB, Ruconest Solutions. Phone: 1-855-613-4HAE	Quantity: 0 Refills: 0
<input type="checkbox"/> Takhzyro	<input type="checkbox"/> 150 mg/mL Syringe <input type="checkbox"/> 300 mg/2 mL Syringe	<input type="checkbox"/> Administer 150 mg every ____ weeks via subcutaneous injection <input type="checkbox"/> Administer 300 mg every ____ weeks via subcutaneous injection	Quantity: <input type="checkbox"/> 28-day supply <input type="checkbox"/> Other: _____ Refills: <input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____
MEDICATION/SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS	
Catheter <input type="checkbox"/> PIV <input type="checkbox"/> PORT <input type="checkbox"/> PICC	IV	Catheter Care/Flush – Only on drug admin days – SASH or PRN to maintain IV access and patency 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 access port a cath	
<input type="checkbox"/> Epinephrine **nursing requires**	<input type="checkbox"/> IM <input type="checkbox"/> SC	<input type="checkbox"/> Adult 1:1000, 0.3 mL (>30 kg/>66 lbs) <input type="checkbox"/> Peds 1:2000, 0.3 mL (15-30 kg/33-66 lbs) <input type="checkbox"/> 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	

☐ Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

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

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.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.

This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Specialty and/or one of its affiliates.