

Hereditary Angioedema (HAE) Enrollment Form



Fax Referral To: 1-800-323-2445 Phone: 1-888-795-4504
Email Referral To: Customer.ServiceFax@CVSHealth.com



Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ DOB: _____
Address: _____ City, State, ZIP Code: _____
Gender: Male Female
Preferred Contact Methods: Phone (to primary # provided below) Text (to cell # provided below) Email (to email provided below)
Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: _____ Alternate Phone: _____
If **Minor**, Parent/Caregiver/Guardian Name (Last, First): _____
Relationship to minor: _____
Email: _____ Last Four of SSN: _____ Primary Language: _____

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)

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

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Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____
 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	300 mg/mL Syringe	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)

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