Hereditary Angioedema (HAE) Enrollment Form

CVS specialty®

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

Coram® CVS specialty® infusion services

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

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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
☐ 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: ☐ 1 year ☐ Other: _____
☐ 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: ☐ 30-day supply ☐ _____ Refills: ☐ 1 year ☐ Other: _____
☐ 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: ☐ 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: 0 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: Dispense ____ 30 mg doses. Keep at least three 30 mg doses on 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 ☐ 300 mg/2 mL Syringe	☐ Administer 150 mg every ____ weeks via subcutaneous injection ☐ Administer 300 mg every ____ weeks via subcutaneous injection	Quantity: ☐ 28-day supply ☐ Other: _____ Refills: ☐ 1 year ☐ Other: _____

MEDICATION/SUPPLIES	ROUTE	DOSE/STRENGTH/DIRECTIONS
Catheter ☐ PIV ☐ PORT ☐ 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
☐ Epinephrine **nursing requires**	☐ IM ☐ SC	☐ Adult 1:1000, 0.3 mL (>30 kg/>66 lbs) ☐ 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 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	May Substitute / Product Selection Permitted / Substitution Permissible
Prescriber's Signature: _____ Date: _____	**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.