

Hereditary Angioedema (HAE) REFERRAL FORM

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1

Patient Name: _____ DOB: _____ Gender: MALE FEMALE
 Address: _____ City/State/Zip: _____
 Primary Phone: _____ Email: _____ SSN: _____ Primary Language: _____
 Emergency Contact: _____ Relationship to Patient: _____ Phone: _____

2 **INSURANCE**

(Please attach **If Available** a copy of the Patients' insurance card(s) Front/ Back)

Primary Insurance: _____ Policy No: _____ Group: _____
 Primary RX Insurance: _____ ID No: _____ RX GRP: _____ RX BIN: _____ RX PCN: _____

3 **DIAGNOSIS AND CLINICAL INFORMATION**

Diagnosis (ICD-10) and Patient Clinical Information:

D84.1 Defects in the Complement System Other Code: _____ Description: _____

Drug Allergies: _____ NKDA Ht: _____ in/cm Wt: _____ lbs/Kg

Check all that apply:

Patient is **naive** to HAE therapy Patient is continuing HAE therapy of _____ Other drugs used to treat HAE: _____

Nursing: Specialty pharmacy to coordinate injection training/ home health infusion nurse visit necessary Yes No

Injection training not necessary. Date training occurred: ___/___/___

Reason: MD office training patient Pt already independent Referred by MD to alternate trainer

4 **PRESCRIPTION INFORMATION**

ACCESS: IV PORT SUBCUTANEOUS N/A

PRODUCT: ANDEMBRY BERINERT HAEGARDA icatibant acetate (FIRAZYR) Other: _____

DOSE: _____ Direction: _____

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PRE/POST ORDERS:

MEDICATION	DIRECTION	QUANTITY	REFILLS
<input type="checkbox"/> SoluMedrol® (IV)	Give _____ mg prior to infusion via <input type="checkbox"/> IV push <input type="checkbox"/> diluted in _____ mL of NS over 30 min.	Quantity: Q.S	Refills: PRN
<input type="checkbox"/> Diphenhydramine: <input type="checkbox"/> PO <input type="checkbox"/> IV	Administer _____ mg 30-60 min Prior to infusion. May repeat every _____ hours PRN.	Quantity: Q.S	Refills: PRN
<input type="checkbox"/> Acetaminophen (PO)	Administer _____ mg PO 30-60 min Prior to infusion. May repeat every _____ hours PRN.	Quantity: Q.S	Refills: PRN
<input type="checkbox"/> Hydration: <input type="checkbox"/> 0.9% NaCl <input type="checkbox"/> LR	Infuse _____ mL of _____ solution <input type="checkbox"/> before <input type="checkbox"/> after infusion.	Quantity: Q.S	Refills: PRN
<input type="checkbox"/> Emla® cream	Apply topically 30 to 60 minutes prior to access.	Quantity: Q.S	Refills: PRN

ANAPHYLAXIS PROTOCOL:

MEDICATION	DIRECTION	QUANTITY	REFILLS
<input type="checkbox"/> EPINEPHRINE (vial or autoinjector)	Administer IM for severe anaphylactic reaction. May repeat in 5-15 minutes <input type="checkbox"/> 0.3 mg (Wt > 30 kg) <input type="checkbox"/> 0.15 mg (Wt 15-30 kg) <input type="checkbox"/> 0.1 mg (Wt 7.5-15 kg)	Quantity: (x1) Vial of (x2) Pen(s)	Refills: PRN
<input type="checkbox"/> DIPHENHYDRAMINE (50mg/mL)	Administer via IM or slow IV push for severe anaphylactic reaction. <input type="checkbox"/> 50 mg (Wt > 30 kg) <input type="checkbox"/> 25 mg (Wt 15-30 kg) <input type="checkbox"/> 12.5mg (Wt 7.5-15kg)	Quantity: (x1) Vial	Refills: PRN
<input type="checkbox"/> SODIUM CHLORIDE 0.9% (IV)	Infuse 500 mL IV as directed for severe anaphylactic reaction.	Quantity: Q.S	Refills: PRN

NURSING/ LABS/ INFUSION SUPPLIES:

NURSING: Nursing visits with each infusion to establish venous access, administer medication, assess and monitor patient, provide education, and complete lab draws.

INFUSION SUPPLIES: Infusion supplies and infusion pump PRN for the administration and disposal of medication.

FLUSHING PROTOCOL: Sodium chloride 0.9%, Up to 10 mL before/after medication, and/or PRN to maintain patency.

Heparin: 10 Units/mL 100 Units/mL, _____ as final flush and/or PRN to maintain patency

LABS: [Dx code: Z79.899]; Labs to be drawn by RN prior to infusion every _____ Week Month(s), as followed:

CMP CBC w/ diff Other: _____

5 **PRESCRIBER SIGNATURE REQUIRED**

(STAMP SIGNATURE NOT ALLOWED)

Prescriber Name: _____ Title: MD DO ND PA APRN NPI: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____ Contact Person: _____

DISPENSE AS WRITTEN BRAND MEDICALLY NECESSARY DO NOT SUBSTITUTE May Substitute / Product Selection Permitted / Substitution Permissible
 NO SUBSTITUTION / DAW / MAY NOT SUBSTITUTE

Prescriber's Signature: _____ Date: _____ Prescriber's Signature: _____ Date: _____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution." NY & IA: electronic prescription required.

Prescribers are to comply with state-specific prescription regulations, which may include requirements for electronic prescribing, generic substitution, authorized prescription formats, and fax language. Noncompliance with these requirements may prompt follow-up communication with the prescriber.

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. I authorize IV Solutions RX and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future refills of the same prescription for the patient listed above. I understand that I can revoke the designation at any time by providing written notice to IV Solutions RX.

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THANK YOU FOR YOU TRUSTING US WITH YOUR PATIENTS SPECIALTY CARE

#welcome to our family