



BERINERT® EXPERT NETWORK (B.E.N.™)
INSURANCE VERIFICATION REQUEST-PRESCRIPTION REFERRAL FORM
FAX: 1-866-415-2162 TOLL FREE: 1-877-BEN-4HAE (1-877-236-4423)

Please complete the form. Submit via fax. Upon completion, benefit information form will be faxed to you. Information may be shared with specialty pharmacies or other providers that may be able to assist you.

PATIENT INFORMATION

Name _____ DOB _____ SSN _____
Address _____ Alternate Contact _____
City _____ State _____ ZIP _____ Sex M F Weight _____ Current Therapy _____
Home Tel _____ Business Tel _____

PATIENT INSURANCE INFORMATION (Fax copy of insurance card[s] and provide the information below)

| | |
|---|---|
| Insurance Company Name 1 _____ | Insurance Company Name 2 _____ |
| MD Participating Status (check one) <input type="checkbox"/> In Network <input type="checkbox"/> Out of Network | MD Participating Status (check one) <input type="checkbox"/> In Network <input type="checkbox"/> Out of Network |
| Policyholder's Name _____ | Policyholder's Name _____ |
| Employer _____ | Employer _____ |
| Insurance Phone _____ Fax _____ | Insurance Phone _____ Fax _____ |
| Group # _____ Policy # _____ | Group # _____ Policy # _____ |

The information on this form is accurate and complete. I hereby authorize my healthcare providers, health plans and insurers to release medical and other pertinent information to AccessMED and/or its authorized designee for the sole purpose of determining medical insurance benefits.

I authorize AccessMED to provide my contact information to U.S. Hereditary Angioedema Association

PATIENT'S SIGNATURE: _____ **DATE:** _____

SELECT ONE:

Berinert® Expert Network (B.E.N.™) to perform insurance verification to determine in-network provider

Or Select Preferred Specialty Pharmacy (SP): Accredo BioRx Caremark Coram IgG America Walgreens/ OptionCare

Is patient currently being serviced by SP? Yes

DOSING AND ADMINISTRATION: 20 Units per Kilogram at a rate of 4 mL per minute | **Berinert® is available in 500 Unit single-use vials**

PRESCRIPTION FORM

Once the Berinert® Expert Network completes the insurance verification, they will send the prescription to one of the specialty pharmacy partners for service.

Product _____ Dosing _____ Patient Weight _____ Refills _____

RX _____

Delivery Method _____ Administration Rate/Time _____

Prescription Type: New Continuing Therapy Restart Drug Allergies _____ NKA

Physician's Full Name _____

Facility Name _____

Facility or Physician Tax ID # _____ DEA # _____

State License # _____ NPI _____

Address _____ City/State/ZIP _____

Office Contact _____ Phone _____ Fax _____

Special Instructions _____

Pharmacy to provide anaphylactic kit per provider protocol Must select: Dispense as Written Substitution Permitted

Physician Authorization (Required)

I certify that Berinert® is medically necessary for this patient. I will be supervising the patient's treatment accordingly. Non-approval of Berinert® may result in further deterioration of patient's health and/or hospitalization. By signing below, I certify that I have received the necessary written authorization to release the medical and/or other patient information referenced on this form relating to the above-referenced patient to CSL Behring's contracted agent or contractors for the purpose of seeking reimbursement through the Berinert® Expert Network (B.E.N.™), verifying insurance coverage and/or the evaluation of the patient's eligibility for alternate sources of funding, and product fulfillment via specialty pharmacies.

PHYSICIAN'S SIGNATURE (required to process prescription) _____ **Date** _____

If you have questions, please call the Berinert® Expert Network (B.E.N.™) toll-free at 1-877-BEN-4HAE (1-877-236-4423).