Please fax all pages of completed form to your team at 866.233.7151.
To reach your team, call toll-free 866.820.4844.
You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Accredo® Specialty Pharmacy Prescription & Enrollment Form

Hereditary Angioedema (HAE)

EVERNORTH HEALTH SERVICES

Four simple steps to submit your referral.

1 Patient Information

Please provide copies of front and back of all medical and prescription insurance cards.

☐ New patient ☐ Current patient

Patient's first name _____ Last name _____ Middle initial _____

Sex at birth: ☐ Male ☐ Female Gender identity _____ Pronouns _____ Last 4 digits of SSN _____

Date of birth _____ Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email address _____

Parent/guardian (if applicable) _____

Patient's primary language: ☐ English ☐ Other If other, please specify _____

Provider will read the following statement to patient: By providing the phone number(s) and email address above, you consent to receiving automated/artificial voice calls, emails and/or text messages from Accredo about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies.

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Office/clinic/institution name _____

Prescriber info: Prescriber's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Office phone _____ Fax _____ NPI # _____ License # _____

Office contact and title _____ Office contact email _____

Office street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion location: ☐ Patient's home ☐ Prescriber's office ☐ Infusion site If infusion site, complete information below dotted line:

- - - -

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

Medication	Strength/Formulation	Directions	Quantity/Refills
Andembry® (garadacimab-gxii)—Fax mandatory hub form found here: https://www.accredo.com/prescribers/referral-forms/andembry.pdf to 866.415.2162			
☐ Berinert (C1 Esterase Inhibitor [human])	500 unit vial	Infuse _____ units by slow IV injection at a rate of 4mL per minute as needed for acute hereditary angioedema (HAE) attack. Where clinically appropriate, please make dose divisible by 500 to avoid wastage.	Dispense: _____ doses. Keep at least _____ doses on hand at all times. Refill x 1 year unless noted otherwise. ☐ Other _____
☐ Cinryze (C1 Esterase Inhibitor [human])	500 unit vial	Infuse _____ units by slow IV injection at a rate of 1mL per minute every _____ days. Where clinically appropriate, please make dose divisible by 500 to avoid wastage.	Dispense: 1-month supply. Refill x 1 year unless noted otherwise ☐ Other
☐ Ekterly® (sebetralstat)	300mg tablet	☐ Take 2 tablets (600mg) by mouth at the earliest recognition of an HAE attack. ☐ Take 1 tablet (300mg) by mouth at the earliest recognition of an HAE attack. If response inadequate, or if symptoms worsen or recur, may repeat dose 3 hours later. Maximum of 2 doses in 24 hours.	Dispense: _____ doses. Keep at least _____ doses on hand at all times. Refill x 1 year unless noted otherwise. ☐ Other _____
Haegarda® (C1 Esterase Inhibitor Subcutaneous [human])—Fax mandatory hub form found here: https://accredo.com/prescribers/referral_forms/haegarda.pdf to 866.415.2162			
☐ icatibant	30mg/3mL prefilled syringe	Administer 30mg subcutaneously over at least 30 seconds for an acute attack of hereditary angioedema. If response is inadequate or symptoms recur, additional injections of 30mg may be administered at intervals of at least 6 hours. Do not administer more than 3 doses in 24 hours.	Dispense: _____ 30mg doses Keep at least three 30mg doses on hand at all times (unless noted otherwise _____ doses). Refill x 1 year unless noted otherwise ☐ Other _____
You must note the name of the brand product if brand is medically necessary for your patient _____			
Infusion Requirements (for Kalbitor and patients who receive in-home nursing for Cinryze and Berinert administration)			
Adverse reaction medications: *(keep on hand at all times)* Diphenhydramine 25mg by mouth or IV (for Kalbitor only) for mild allergic reactions and 50mg for moderate-severe. • <9kg: Diphenhydramine 1mg/kg up to max of 6.25mg • 2–5 years old and >9kg: Diphenhydramine 6.25mg to 12.5mg • 6–12 years old: Diphenhydramine 12.5mg to 25mg Epinephrine 0.3mg auto-injector 2-pk for patient weighing greater than or equal to 30kg. Administer intramuscularly as needed for severe anaphylactic reaction times one dose; may repeat one time. Epinephrine 0.15mg auto-injector 2-pk, for patient weighing less than 30kg. Administer intramuscularly as needed for severe anaphylactic reaction times one dose; may repeat one time. For Kalbitor only: Normal Saline 250mL intravenously for anaphylactic reaction. Infuse wide open up to a max of 250mL per hour. Normal Saline 3mL flush before and after intravenous diphenhydramine administration and as needed for line patency.			Refill x 1 year unless noted otherwise ☐ Other _____
Flushing orders (for Cinryze and Berinert only): Normal saline 3mL intravenous (peripheral line) or 10mL intravenous (central line) before and after infusion, or as needed for line patency Heparin 100 units per mL 5mL intravenous (central line) as needed for final flush			
Ancillary Supplies for all HAE products			
Dispense needles, syringes and ancillary supplies necessary to administer medication.			Refill x 1 year unless noted otherwise
Nursing Start of Care Orders for all HAE products			
Skilled nursing visit to provide patient education related to therapy, disease state, self and/or nurse administer of medication as prescribed. Visit frequency based on prescribed medication and dosage orders.			

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE

_____ **Date** _____ **Dispense as written** _____ **Date** _____ **Substitution allowed**

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

Medication	Strength/Formulation	Directions	Quantity/Refills
☐ Kalbitor (ecallantide)	10mg/mL vial	Administer 30mg (3mL) subcutaneously in three 10mg (1mL) injections for an acute attack of hereditary angioedema. If the attack persists, may repeat the dose one time within a 24 hour period.	Dispense: Two 30mg doses. Keep at least two 30mg doses on hand at all times. Refill x 1 year unless noted otherwise ☐ Other _____
Kalbitor should only be administered by a healthcare professional with appropriate medical support to manage anaphylaxis. ☐ Kalbitor to be infused in physician's office or controlled medical setting and/or ☐ Home infusion allowed by a Kalbitor trained RN			
Ruconest (C1 Esterase Inhibitor [recombinant])—Fax mandatory hub form found here: https://accredo.com/prescribers/referral_forms/ruconest.pdf to 855.423.5757			
☐ Takhzyro (lanadelumab-flyo)	☐ 300mg/2mL prefilled syringe	☐ 300mg by subcutaneous injection every two weeks ☐ 300mg by subcutaneous injection every four weeks	Dispense: 1-month supply. Refill x 1 year unless noted otherwise ☐ Other _____ Takhzyro should be administered by a healthcare provider or caregiver if that patient is under 12 years of age.
	☐ 150mg/1mL prefilled syringe	☐ 150mg by subcutaneous injection every two weeks ☐ 150mg by subcutaneous injection every four weeks	
You must note the name of the brand product if brand is medically necessary for your patient _____			
Infusion Requirements (for Kalbitor and patients who receive in-home nursing for Cinryze and Berinert administration)			
Adverse reaction medications: *(keep on hand at all times)* Diphenhydramine 25mg by mouth or IV (for Kalbitor only) for mild allergic reactions and 50mg for moderate-severe. • <9kg: Diphenhydramine 1mg/kg up to max of 6.25mg • 2–5 years old and >9kg: Diphenhydramine 6.25mg to 12.5mg • 6–12 years old: Diphenhydramine 12.5mg to 25mg Epinephrine 0.3mg auto-injector 2-pk for patient weighing greater than or equal to 30kg. Administer intramuscularly as needed for severe anaphylactic reaction times one dose; may repeat one time. Epinephrine 0.15mg auto-injector 2-pk, for patient weighing less than 30kg. Administer intramuscularly as needed for severe anaphylactic reaction times one dose; may repeat one time. For Kalbitor only: Normal Saline 250mL intravenously for anaphylactic reaction. Infuse wide open up to a max of 250mL per hour. Normal Saline 3mL flush before and after intravenous diphenhydramine administration and as needed for line patency.			Refill x 1 year unless noted otherwise ☐ Other _____
Flushing orders (for Cinryze and Berinert only): Normal saline 3mL intravenous (peripheral line) or 10mL intravenous (central line) before and after infusion, or as needed for line patency Heparin 100 units per mL 5mL intravenous (central line) as needed for final flush			
Ancillary Supplies for all HAE products			
Dispense needles, syringes and ancillary supplies necessary to administer medication.			Refill x 1 year unless noted otherwise
Nursing Start of Care Orders for all HAE products			
Skilled nursing visit to provide patient education related to therapy, disease state, self and/or nurse administer of medication as prescribed. Visit frequency based on prescribed medication and dosage orders.			

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE _____ _____ _____ _____

Date **Dispense as written** **Date** **Substitution allowed**

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

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Prior Authorization Checklist Hereditary Angioedema (HAE)

Providing Accredo, Evernorth's specialty pharmacy, with the documentation outlined in this checklist may increase the likelihood and speed of obtaining coverage for your patients with HAE. Coverage criteria may vary by payer.

Enrollment form

- ☐ **Completed** HAE enrollment form[1,2]
- ☐ **Copy of** medical insurance card
- ☐ **Copy of** prescription benefits card

Clinical documents

- ☐ **History of** present illness (HAE)
- ☐ **C1-inhibitor** functional (or mutation) levels
- ☐ **C4 antigenic** levels
- ☐ **Medication profile** including any tried and failed therapies

Prescriber specialization

- ☐ Allergist
- ☐ Immunologist
- ☐ Hematologist
- ☐ Rheumatologist
- ☐ Other

Fax completed form to 866.233.7151.

If you have any questions, please call your Accredo provider support advocate, or call 866.820.4844.

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[1] For enrollment forms visit accredo.com.
[2] Accredo enrollment form not required for electronic prescriptions or if using manufacturer hub form.

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