Please fax both 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.

Prescription & Enrollment Form
Hereditary Angioedema (HAE)

accredo®

Four simple steps to submit your referral.

☐ Do not contact patient, benefits check only

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 _____

☐ Male ☐ Female Last 4 digits of SSN _____ Date of birth _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ E-mail address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ E-mail address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ E-mail address _____

☐ OK to leave message with alternate caregiver/contact

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

Insurance Company _____

Phone _____ Identification # _____ Policy/group # _____

Prescription card: ☐ Yes ☐ No If yes, carrier _____ Policy #: _____ Group #: _____

Is patient eligible for Medicare? ☐ Yes ☐ No Does patient have secondary insurance? ☐ Yes ☐ No

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____

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 e-mail _____

Office street address _____ Suite # _____

City _____ State _____ Zip _____

3 Clinical Information

Primary ICD-10 code (REQUIRED): _____ ☐ **D84.1 C1 esterase inhibitor [C1-INH] deficiency**

☐ Other _____ ☐ Other drugs used to treat the disease _____

Weight _____ kg/lbs Date recorded _____ Height _____ cm/in Date recorded _____

☐ NKDA ☐ Known drug allergies _____

Adverse reactions with previous HAE treatments? _____

If so, what brand of HAE caused the reaction? _____

☐ Patient is naïve to HAE therapy ☐ Patient is continuing HAE therapy of _____

☐ Patient to infuse in ER/MDO ☐ Home infusion allowed Concurrent meds _____

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

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

Medication	Dose	Directions	Quantity/Refills
☐ 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 _____
☐ 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 _____
Haegarda® (C1 Esterase Inhibitor Subcutaneous [human])—Fax mandatory hub form found here: https://accredo.com/prescribers/referral_forms/haegarda.pdf to 866.415.2162			
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 _____
☐ icatibant	30mg/3mL	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). ☐ Other _____
☐ 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			
You must note the name of the brand product if brand is medically necessary for your patient _____			
Infusion Requirements (for Cinryze, Berinert and Kalbitor)			
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 12.5 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 0.15 mg auto-injector 2-pk, for patient weighing less than 30 kg. 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 and normal saline 3mL flush before and after intravenous diphenydramine 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 ☐ Other _____
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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