Fax Referral To: 800-323-2445
Phone: 800-237-2767

Hereditary Angioedema
Enrollment Form

Date: ___________ Needs by Date: ___________

Ship to: ☐ Patient ☐ Office ☐ Other: ___________

PATIENT INFORMATION
(*Complete the following* ***or send patient demographic sheet***)

Patient Name: ___________
Address: ___________
City, State, Zip: ___________
Home Phone: ___________
Alternate Phone: ___________
SS #: ___________
Date of Birth: ___________ Gender: ___________

PRESCRIBER INFORMATION

Prescriber's Name: ___________
State License #: ___________ UPIN: ___________
DEA #: ___________ NPI #: ___________
Group or Hospital: ___________
Address: ___________
City, State Zip: ___________
Phone: ___________ Fax: ___________
Contact Person: ___________ Phone: ___________

INSURANCE INFORMATION (*Please copy and attach the front and back of insurance and prescription drug card*)

Prescription Card: Name of Insurer: ___________ ID#: ___________ BIN: ___________ PCN: ___________ Group: ___________
Primary Insurance: Subscriber: ___________ ID#: ___________ Name of Insurer: ___________ Phone: ___________
Secondary Insurance: Subscriber: ___________ ID#: ___________ Name of Insurer: ___________ Phone: ___________

STATEMENT OF MEDICAL NECESSITY

Diagnosis:
☐ 277.6 HAE
☐ ___________
• Date of Diagnosis: ___________

Patient Evaluation:
• Disease State: ☐ Pregnancy (Due Date: ___________)
• Frequency of attacks: ___________ Severity of attacks: ☐ Mild ☐ Moderate ☐ Severe
- Location of attacks: ☐ Facial ☐ Laryngeal ☐ Abdominal ☐ Extremity ☐ Urogenital
- Days of incapacitation per year: ___________
• Vaccinations: ☐Hepatitis B Date: ___________ ☐Influenza Date: ___________ ☐Pneumoccocal Date: ___________
• Any anticipated surgeries? ☐ Yes ☐ No • If Yes, Date: ___________
• Height: ___________ in/cm • Weight: ___________ kg/lbs • Date of Measurement: ___________
• Allergies: ___________
• Concomitant Medications: ___________

Site of Care:
☐ Physician Office ☐ Infusion Clinic ☐ Hospital Outpatient ☐ Home Health ☐ Other: ___________
• If Home Health, preferred agency? ___________
☐ Request training for self-infusion*
*Cinryze® is the only current HAE treatment approved for self-administration.

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Berinert® (Indicated for treatment of acute abdominal and facial attacks of HAE in adults and adolescents.)	☐ 500 units	☐ 20 units per kg body weight Directions: ___________		
*☐ Cinryze® (Indicated for treatment of routine prophylaxis of angioedema attacks in adults and adolescents with HAE.)	☐ 500 units	☐ 1000 units (2 vials) every 3-4 days. ☐ Additional Instructions: ___________		
☐				
☐				

*Please complete a Cinryze® Solutions enrollment form and indicate CVS Caremark as the specialty pharmacy. You can obtain by calling 1-877-945-1000

Other Medications

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ EpiPen®				
☐				

Ancillary Supplies and Kits Provided as Needed for Administration.

PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)

IMPORTANT NOTICE: *This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. Hereditary Angioedema 092910*