For assistance, contact your pharmacy representative: _____ Phone:_____**(For providers only)**

PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.

Note: This form is intended for prescriber use only, if faxed, the fax must come from MD office or hospital **(may not be faxed by patient)**.

allianceRx Walgreens Pharmacy

Hereditary Angioedema (HAE)

Prescription/Pharmacy Intake Form

Pharmacy: Specialty360 HAE Team

Pharmacy Fax: 866-889-1667 Pharmacy Phone: 877-865-9035

Date Needed: _____ **Ship To:** ☐Prescriber's Office ☐Patient's Home ☐Other: _____

PATIENT INFORMATION

Patient name: _____ DOB: _____ ☐Male ☐Female

Address: _____

City: _____ State: _____ Zip code: _____

Phone # (Daytime): _____ Phone # (Evening): _____

E-mail Address: _____ Case Manager: _____

Insurance provider **(Please include copy of front and back of card)**: _____

ID #: _____ Policy/Group #: _____ Phone #: _____ ☐Patient is eligible for Medicare

Name of Insured: _____ Employer: _____

Relationship to Patient: ☐Self ☐Other: _____ Prescription Card: ☐Yes ☐No Carrier: _____ Policy/Group #: _____

Will there be access to anaphylactic medications and oxygen at the administration site? _____

CLINICAL ASSESSMENT – Please complete ALL sections to avoid delays in filling prescription.

☐Patient is new to therapy ☐Patient is restarting therapy ☐Patient is currently on therapy Start date: _____

ICD-10 code: ☐D84.1 ☐Other (please specify) _____ Date of Diagnosis: _____

Other Diagnosis/Conditions: _____ Concomitant Drugs for HAE: _____

Concomitant Medications: _____ Allergies: _____

Locations of Angioedema: ☐Abdomen ☐Face ☐Extremities ☐Throat ☐Other _____

Current Weight: _____ ☐lb ☐kg Date: _____ Current Height: _____ ☐in ☐cm Date: _____

☐Other Therapies Tried & Failed (Please List): _____

Flushing orders: ☐Normal saline 3mL - 5mL intravenous (peripheral line) or 5mL - 10mL intravenous (central line) before and after infusion, or as needed for line patency

☐Heparin 10units/mL (3mL - 5mL) use as a final flush for peripheral line ☐Heparin 100units/mL (3mL - 5mL) use as a final flush for central line

OPTIONAL SPECIALTY PHARMACY NURSING ORDERS

Location of Skilled Nursing: ☐Home ☐Other: _____

Skilled nursing visit as needed to provide patient education related to therapy, disease state, self and/or nurse administration of medication as prescribed. (Select 1 option below)

☐Provide ongoing nursing visits for administration and education until patient/caregiver is independent with self infusion.

☐Provide ongoing nursing visits for On Demand infusions, patient/caregiver unable or unwilling to learn self infusion.

☐No nursing required; patient is independent with self infusion.

Visit frequency (based on medication order and dosage order) and patient's/caregiver's ability to self-administer: _____

PRESCRIPTION INFORMATION

Medication	Dose/Directions/Frequency	Quantity	Refills
☐Berinert 500 IU			
☐Firazyr 30mg/3mL syringe			
☐Haegarda	Please complete a Haegarda Connect℠ Prescription & Service Request Form and fax it to Haegarda Connect at 1-866-415-2126		
☐Ruconest	Please complete a Ruconest Solutions Patient Enrollment Form and fax it to Ruconest Solutions at 1-855-423-5757		
☐Epinephrine injection ☐0.15 mg ☐0.3 mg	Use as directed		
I authorize, by my signature below, the dispensing of appropriate needles and syringes, in a sufficient quantity, required for the administration of injectable products by patient or caregiver. Authorization for supplies runs concurrently with the number of refills or time frame specified for the drug.			

PRESCRIBER INFORMATION

Prescriber's name: _____ Practice/facility: _____

Address: _____ City: _____ State: _____ Zip code: _____

Office contact: _____ Phone: _____ Fax: _____

Email: _____ Best time to call: _____ Preferred method of contact: ☐Email ☐Phone ☐Fax

State license #: _____ DEA #: _____ NPI #: _____ Medicaid UPIN #: _____

In order for a brand name product to be dispensed, the prescriber must handwrite **"Brand Necessary"** or **"Brand Medically Necessary"** or your state specific required language after their signature. I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

_____ Dispense as written

_____ Substitution permitted

_____ Date

***** THIS FORM IS NOT VALID IN THE STATE OF ALABAMA *** 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.** The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

Drug names are the property of their respective owners.