



Patient Information

patient: _____ last name, first name male female DOB: _____ SS#: _____

address: _____ street _____ city _____ state _____ zip

primary phone number: _____ cell alternate phone number: _____ cell

height: _____ weight: _____ lbs kgs date: _____

allergies: _____

emergency contact: _____ primary phone number: _____ cell alternate phone number: _____ cell

Insurance

primary insurance:		subscriber name:	
policy number:	group number:	PCN:	
RX BIN:	insurance phone:		
secondary insurance:		subscriber name:	
policy number:	group number:	PCN:	
RX BIN:	insurance phone:		

Medical Necessity

277.6 HAE date of diagnosis: _____ other ICD-9: _____ description: _____

pregnancy due date: _____ frequency of attacks: _____

type: <input type="checkbox"/> type 1 <input type="checkbox"/> type 2 <input type="checkbox"/> unknown lab confirmation: <input type="checkbox"/> C1 level <input type="checkbox"/> C4 level <input type="checkbox"/> no	location: <input type="checkbox"/> facial <input type="checkbox"/> laryngeal <input type="checkbox"/> abdominal <input type="checkbox"/> extremity <input type="checkbox"/> urogenital	days of missed work/school per year: ____
---	--	---

vaccinations: <input type="checkbox"/> Hepatitis B date _____ <input type="checkbox"/> Influenza date _____ <input type="checkbox"/> Pneumococcal date _____	anticipated surgeries: <input type="checkbox"/> yes <input type="checkbox"/> no date: _____
---	--

Site of Care/Ship To:

<input type="checkbox"/> physician office <input type="checkbox"/> infusion suite <input type="checkbox"/> home health agency (preferred agency) _____ <input type="checkbox"/> request training for self-injection for Firazyr® <input type="checkbox"/> other _____	ship to: <input type="checkbox"/> patient <input type="checkbox"/> MD office <input type="checkbox"/> other _____ NEED BY DATE: _____
---	---

other current HAE medications: _____

Prescription:	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Firazyr®	<input type="checkbox"/> 30mg/3ml <input type="checkbox"/> 1 – syringe pack <input type="checkbox"/> 3 – syringe pack	Inject 30mg subcutaneously into abdominal area. If response is inadequate or symptoms recur, additional injections of 30mg may be administered at 6 hour intervals with a maximum of 3 doses within 24 hours.		

Physician:

MD: _____ last name, first name licence: _____ NPI: _____

hospital/clinic: _____ phone: _____

address: _____ street _____ city _____ state _____ zip fax: _____

office contact: _____ medicaid number: _____

I authorize Rx International Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

physician signature: _____ date: _____

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by calling (305) 221-1421 or by emailing pharmacy@rxipharma.com to obtain instructions as to the proper destruction of the transmitted material. Thank you.