Hereditary Angioedema

Rx International Pharmacy

Phone: (305) 221-1421
Fax: (305) 221-3275

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: ☐ type 1 ☐ type 2 ☐ unknown

lab confirmation: ☐ C1 level ☐ C4 level ☐ no

location: ☐ facial ☐ laryngeal ☐ abdominal ☐ extremity ☐ urogenital

days of missed work/school per year: ____

vaccinations: ☐ Hepatitis B *date* _____ ☐ Influenza *date* _____ ☐ Pneumoccocal *date* _____

anticipated surgeries: ☐ yes ☐ no **date:** _____

Site of Care/Ship To:

☐ **physician office**

☐ **infusion suite**

☐ **home health agency** *(preferred agency)* _____

☐ **request training for self-injection for Firazyr®**

☐ **other** _____

ship to: ☐ patient ☐ MD office ☐ other _____

NEED BY DATE: _____

other current HAE medications: _____

Prescription:	**Strength**	**Directions**	**Quantity**	**Refills**
☐ Firazyr®	☐ 30mg/3ml ☐ 1 – syringe pack ☐ 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:**