WELLPARTNER PHARMACY | HEREDITARY ANGIOEDEMA ENROLLMENT FORM

FAX FORM TO: 1.877.597.3070 | **PHONE:** 1.800.473.3516 | **EMAIL:** specialty@wellpartner.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION

Name:
Address:
City, State, ZIP:
Primary Phone: - - DOB: / /
Alternate Phone: - - Gender:
Email:
Primary Language: Last Four of SSN:

2. PRESCRIBER INFORMATION

Name:
DEA #: NPI #: State Lic. #:
Group or Hospital:
Address:
City, State, Zip:
Phone: - - Fax: - -
Contact Person: Phone: - -

3. INSURANCE INFORMATION

*Fax copy of **prescription** and **insurance cards** with this form, if available (front and back)*

Primary Insurance Company Name:
Primary Cardholder Name:
Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent
Phone: - - Member ID: Group #:

Secondary Insurance Company Name:
Secondary Cardholder Name:
Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent
Phone: - - Member ID: Group #:

4. DIAGNOSIS AND MEDICAL NECESSITY

Needs by Date: / / Ship to: ◯ Patient ◯ Office ◯ Other:
Date of Diagnosis: / / Is patient pregnant? ◯ Yes ◯ No If yes, due date: / /
◯ D84.1 Defects in the complement system Frequency of attacks: Severity of attacks: ◯ Mild ◯ Moderate ◯ Severe
◯ Other: Location of attacks: ◯ Facial ◯ Laryngeal ◯ Abdominal ◯ Extremity ◯ Urogenital
Type: ◯ Type 1 ◯ Type 2 ◯ Unknown Days of incapacitation per year:
Lab Confirmation: ◯ C1 level ◯ C4 level ◯ None Port? ◯ Yes ◯ No
Height (in/cm): Weight (lb/kg): Any anticipated surgeries? ◯ Yes ◯ No If yes, date: / /
Date of measurement: / / Site of care:
Allergies: ◯ Physician Office ◯ Infusion Clinic ◯ Hospital Outpatient ◯ Home Health ◯ Other:
◯ Request training for self-infusion ◯ Ongoing nursing is required
Concomitant Medications:

5. PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
◯ Firazyr®	30 mg/3 ml ◯ 1- syringe pack ◯ 3- syringe pack	Inject SQ in abdominal area. If response is inadequate or symptoms recur, additional injections of 30 mg may be administered at 6 hour intervals with a max of 3 doses in 24 hours.		
◯ Berinert (LD)*	(LD)* These are limited distribution drugs that require additional handling. Please call (1.800.473.3516) for more information.			
◯ Cinryze (LD)*				
◯ Kalbitor (LD)*				
◯				
◯				

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE

X / /
DISPENSE AS WRITTEN DATE

X / /
PRODUCT SUBSTITUTION PERMITTED DATE