US Bioservices
AmerisourceBergen

HAE Referral Form

Phone: (888) 518-7246
Fax: (888) 418-7246

Deliver to: ☐ Patient's Home ☐ Prescriber's Office ☐ Other:_____ ☐ Hold shipment until notified by prescriber ☐ Anticipated Start Date:_____

1. Patient Information

Patient Name: _____ Home Phone:_____ Work/Mobile Phone:_____

S.S. #:_____ Date of Birth:_____ Home Address:_____

Guardian/Caregiver:_____ City:_____ State:_____ Zip:_____

Patient Preferred Language:_____ Sex: ☐ Male ☐ Female Height:_____ Weight:_____ ☐ lbs. ☐ kg.

2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription & medical)

Medical Insurance:_____ Phone:_____ Prescription Card: _____ Phone:_____

Subscriber Name:_____ Policy #:_____ BIN/PCN:_____

Policy #:_____ Group #:_____ Medicare #:_____ Medicaid #:_____

3. Prescriber Information

Prescriber Name:_____ ☐ MD ☐ DO ☐ NP ☐ PA License #:_____ NPI #:_____ DEA #:_____

Practice Name: _____ Phone:_____ Fax:_____

Address:_____ Office Contact:_____ Phone:_____

City: _____ State:_____ Zip:_____ Collaborating Physician:_____

4. Diagnosis & Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Primary ICD-10:_____ Diagnosis confirmed through lab testing: ☐ Yes ☐ No ☐ C1 Level ☐ C4 Level

Secondary ICD-10:_____ Frequency of attacks (total number over last 12 months:_____

Hereditary Angioedema: ☐ Type 1 ☐ Type 2 ☐ Unknown Drug Allergies:_____ ☐ None

Date of Diagnosis:_____ Concurrent Medications:_____

5. Prescription Information

	MEDICATION(S)	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS
☐	**KALBITOR®**	10 mg/mL SDV	Administer 30 mg (3mL) subcutaneously in three 10 mg (1mL) injections PRN for treatment of acute attacks of hereditary angioedema (HAE). May administer additional 30 mg dose within 24 hours if attack persists. KALBITOR should only be administered by a healthcare professional with appropriate medical support.	2	
☐	**FIRAZYR®**	30 mg/3 mL PFS	Administer 30 mg (3 mL) subcutaneously in the abdominal area PRN for treatment of acute attacks of HAE. May administer additional 30 mg dose at intervals of at least 6 hours if attack persists or symptoms recur. No more than 3 doses (90 mg) should be administered in any 24 hour period.		

6. Preferred Treatment Site

During normal business hours:

☐ Within a prescribers office (same as prescriber information)

☐ Other location:_____

☐ Patient to self-inject after training under the guidance of a healthcare professional:

☐ Administering healthcare professional name:_____

Practice facility name:_____ Specialty:_____

Street address:_____ City, State, Zip:_____

24-hour access:

☐ Within prescriber's office (same as prescriber information)

☐ Other location:_____

☐ Facility name :_____

Street address:_____ City, State, Zip:_____

Patient Support Programs: Please have patient sign and date to enroll in pharmaceutical company assisted patient support program.

Patient Signature _____ Date ____ / ____ / ____

Account Manager

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting. NY prescriptions must be submitted via e-script.)

I authorize US Bioservices Corporation to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature-Substitution Permissible PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. Date ____ / ____ / ____

Prescriber Signature-Dispense as Written PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. Date ____ / ____ / ____