

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: _____ lb kg

2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription and 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 and 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	Dispense	Refills
<input type="checkbox"/>	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	
<input type="checkbox"/>	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 prescriber's 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 ____ / ____ / ____