CYCLE VITA
Support for life

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SAJAZIR™ (icatibant) Injection Enrollment Form

Phone: 888-360-8482 FAX: 888-385-8482 Website: www.sajazir.com

Please see Indication and Important Safety Information on the page 3, including the full Prescribing Information

SAJAZIR™ (icatibant) Injection

To Enroll, Fax this form:
888-385-8482
Or email: hello@cyclevita.life

All required fields are purple and noted with an asterisk*

PATIENT INFORMATION

Patient Name (First, Last)*:		Date of Birth*:	Gender*:
Street Address*:	City*:	State*:	ZIP*:
Email Address:	Cell Phone:	Home Phone:	Preferred Language*:
Caregiver Name (if applicable):	Relation to patient:	Caregiver Phone (if different from patient):	

INSURANCE INFORMATION

Please attach a copy of the prescription insurance benefit card, front and back, or complete the following*

☐ Prescription insurance benefit card attached. ☐ Patient does not have insurance. ☐ Patient requires co-pay only.

Primary Insurance Company Name*		Secondary Insurance Company Name	
Primary Insurance Company Phone Number*		Secondary Insurance Company Phone Number	
Name of Primary Cardholder*		Name of Primary Cardholder	
Primary Insurance Member ID*	Group ID*	Secondary Insurance Member ID	Group ID
BIN*	PCN*	BIN	PCN

Prior Authorization Status

☐ Submitted ☐ Not submitted ☐ Approved ☐ Denied

PRESCRIBER INFORMATION

Prescriber Last Name* :	Prescriber First Name* :	
Prescriber Office/Site/Clinic*		
Prescriber Phone Number*	Prescriber Fax Number*	
Prescriber Medicaid Number*	Prescriber Tax ID*	
Street Address*		
City*	State*	Zip Code*
NPI Number*		
Office Contact Name		
Office Contact Phone Number with extension	Office Email Address	

CLINICAL INFORMATION

Diagnosis*: ☐ ICD-10 D84.1 (HAE). Select a type below*:
- ☐ Type I
- ☐ Type II
- ☐ Normal C1-inhibitor (Type III)

☐ Other: _____

Patient Allergies*: ☐ None Known ☐ Known (please list known allergies): _____	Medications*: ☐ None ☐ Known (please list known medications): _____

Previous Theapy*:

☐ New to Therapy ☐ Currently on icatibant (please list medications): _____ ☐ Other medication (please list): _____

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Patient Full Name:	Date of Birth:

PRESCRIPTION INFORMATION (SAJAZIR™ (Icatibant) 30 mg/3 mL Injection)

Directions:
- The recommended dose of SAJAZIR is 30 mg administered by subcutaneous injection in the abdominal area.
- Additional doses may be administered at intervals of at least 6 hours if response is inadequate or if symptoms recur.
- No more than 3 doses may be administered in any 24 hour period.
- Patients may self-administer upon recognition of an HAE attack after training under the guidance of a healthcare professional
- Please see the full Prescribing Information for additional Important Information.

Dispense:* ☐ One (1) syringes (NDC: 70709-013-01 / 70709001301) Qty: _____ Syringe(s)/Month§
§Dispensed quantity may be restricted or determined by insurance

Refill: _____

Special Instructions:

_____

☐ **Bridge† - "Bridge" is a FREE supply of SAJAZIR that allows patients with an urgent medical need to begin therapy immediately while Cycle Vita secures appropriate benefit verification and authorization. Bridge may also be requested for existing patients who are temporarily experiencing disruption in therapy due to insurance coverage.**

By checking the box above for Bridge, I, as the prescriber, with my signature above on this form, agree and attest that I will not submit a claim to or seek payment from the patient or any third-party payer (e.g., Medicaid, Medicare, private insurance, etc.) for payment/reimbursement for any free product(s) provided by Cycle Vita. I agree and understand that any free product provided by Cycle Vita may not be sold, traded, bartered, transferred, or returned for credit and will only be used for the patient named above on this form. Cycle Vita reserves the right to modify or terminate the program without notice at any time.

† Bridge is at no cost, for eligible patients within labeled indication only, and not contingent on purchase of any kind. Bridge is intended to support continuation of prescribed therapy if there is any disruption in therapy due to insurance coverage.

PRESCRIBER DECLARATION

Prescriber Declaration: I understand and agree that, as the prescriber, I will comply with my state-specific prescription requirements such as e-prescribing, statespecific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to me, as the prescriber. I verify that the patient and prescriber information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed SAJAZIR based on my professional judgment of medical necessity. I authorize Cycle Vita, its affiliates, agents, and contractors (collectively, "Cycle Vita") to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the above-named patient utilizing their benefit plan by any means allowed under applicable law. I authorize Cycle Vita, its affiliates, agents and contractors to perform any steps necessary to secure reimbursement for SAJAZIR, including but not limited to insurance verification and case assessment. I understand that Cycle Vita may need additional information, and I agree to provide it as needed for the purposes of securing reimbursement.

X.....		_____
Prescriber Signature Dispense as Written (DAW) (no stamps or initials)	(Substitution Permitted)	Date of Signature (MM/DD/YYYY)

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SAJAZIR™ (icatibant) Injection

Patient Full Name:	Date of Birth:

INDICATION

SAJAZIR™ (icatibant) injection is indicated for the treatment of acute attacks of hereditary angioedema (HAE) in adults 18 years of age and older.

IMPORTANT SAFETY INFORMATION

Warnings and Precautions

Laryngeal Attacks. Given the potential for airway obstruction during acute laryngeal HAE attacks, patients should be advised to seek medical attention in an appropriate healthcare facility immediately in addition to treatment with SAJAZIR.

Adverse Reactions

The most commonly reported adverse reactions were injection site reactions, which occurred in almost all patients (97%) in clinical trials. Other common adverse reactions occurring in greater than 1% of patients included pyrexia (4%), transaminase increase (4%), dizziness (3%), and rash.

Postmarketing Experience

The following adverse reactions have been identified during post approval use of icatibant: urticaria.

Drug Interactions:

ACE Inhibitors. Icatibant is a bradykinin B2 receptor antagonist and thereby has the potential to have a pharmacodynamic interaction with ACE inhibitors where icatibant may attenuate the antihypertensive effect of ACE inhibitors. Clinical trials to date have excluded subjects taking ACE inhibitors.

Use in Specific Populations

Pregnancy: Available data from published literature and the pharmacovigilance database with icatibant use in pregnant women have not identified a drug-associated risk of major birth defects, miscarriage or adverse maternal or fetal outcomes.
Lactation: The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for icatibant and any potential adverse effects on the breastfed child from icatibant or from the underlying maternal condition.
Pediatric Use: Safety and effectiveness in pediatric patients below the age of 18 years have not been established.
Geriatric Use: Elderly patients are likely to have increased systemic exposure to icatibant injection compared to younger (18-45 years) patients. No dose adjustment is recommended.

For more detailed information, please refer to the full Prescribing Information

To report SUSPECTED ADVERSE REACTIONS contact Cycle Pharmaceuticals at 1-800-836-4380, or the FDA at: 1-800-FDA-1088 or www.fda.gov/medwatch