

## HEREDITARY ANGIOEDEMA (HAE) ENROLLMENT FORM

### 1 PATIENT INFORMATION

*(Please complete the following or send patient demographic sheet)*

Patient Name: \_\_\_\_\_  
 Primary Phone: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Gender: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Allergy: \_\_\_\_\_  
 Patient Weight: \_\_\_\_\_  
 Diagnosis: D84.1 Other \_\_\_\_\_

### 2 PRESCRIBER INFORMATION

Prescriber's Name: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_  
 NPI #: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### 3 INSURANCE INFORMATION

*(Please copy and attach the front and back of insurance and prescription drug card)*

### 4 CATHETER ACCESS AND FLUSH PROTOCOL (If Applicable)

ACCESS TYPE	CATHETER FLUSH ORDERS
Peripheral	<b>0.9% Saline Flush: Dispense: 30 Days Refills: PRN x 1yr</b> Flush line/port with 10mL for patency/SASH protocol.
PORT <i>(Also include Peripheral IV PRN Port Malfunction)</i>	<b>Heparin Flush: Dispense: 30 Days Refills: PRN x 1yr</b> Flush port with _____ mL of Heparin _____ units/mL per SASH protocol.

### 5 PRESCRIPTION INFORMATION

Please check the following:

MEDICATION	DOSE	DIRECTIONS	DAY SUPPLY	QUANTITY	REFILLS
<input type="checkbox"/> BERINERT® (C1 Esterase inhibitor [human])	20 IU/kg	_____	_____	_____	_____
<input type="checkbox"/> CINRYZE® (C1 esterase inhibitor [human])	max 100 IU/kg up to 2500 IU	_____	_____	_____	_____
<input type="checkbox"/> FIRAZYR® (Icatibant acetate) <input type="checkbox"/> Icatibant acetate (generic)	30 mg prefilled syringe	Inject 1 syringe (30mg) subcutaneously in the abdominal area. If response is inadequate or symptoms recur, additional injections of 30mg may be administered at intervals of at least 6 hours.	_____	_____	_____
<input type="checkbox"/> HAEGARDA® C1 Esterase Inhibitor Subcutaneous [human]	max 60 IU/kg	_____	28 Days	<input type="checkbox"/> 2000 IU #of vials _____ <input type="checkbox"/> 3000 IU #of vials _____	13
<input type="checkbox"/> KALBITOR® (ecallantide) injection	30 mg	Administer 30mg (3mL) SC in three 10mg (1mL) injections as needed for acute HAE attack. Dose may be repeated within a 24 hour period.	_____	_____ boxes of three 10mg (1mL) vials	_____
<input type="checkbox"/> RUCONEST® (C1 esterase inhibitor [recombinant])	50 IU/kg max. 4200 units	_____	_____	_____	_____
<input type="checkbox"/> TAKHZYRO® (lanadelumab-flyo) injection	150 mg 300 mg	Administer subcutaneously every 2 weeks (bi-weekly) Administer subcutaneously once monthly (monthly)	28 Days	2 pre-filled syringes (biweekly) 1 pre-filled syringe (monthly)	13

### 6 PHYSICIAN SIGNATURE (Required)

X \_\_\_\_\_ Date of Signature      X \_\_\_\_\_ Date of Signature  
 PRODUCT SUBSTITUTION PERMITTED      DISPENSE AS WRITTEN

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**7 ADDITIONAL INSTRUCTIONS**

**SITE OF CARE**

- Self/caregiver administration training # visits ordered \_\_\_\_\_ or  competent
- Home Health Nursing

**NURSING INSTRUCTIONS**

1. Gain IV access prior to mixing (if applicable).
2. Mix and administer \_\_\_\_\_ according to package insert (main recommendation)

**IN CASE OF EMERGENCY**

1. Stop medication
2. Call doctor
3. Administer emergency med if ordered in box \_\_\_\_\_

**ADMINISTER EMERGENCY MEDS PER PHYSICIAN ORDERS** #q.s. for each drug. Refill: PRN x 1 year

For severe anaphylaxis, administer prescribed epinephrine.

If severe symptoms persist, may repeat. **(Please select epinephrine dose):**

epinephrine 0.3 mg autoinjector IM (patients >30 kg)

epinephrine 0.15 mg autoinjector IM (patients <30 kg)

- Diphenhydramine \_\_\_\_\_ mg IV push over 2-5 minutes for Infusion Reaction
- Corticosteroid (specify drug and dose):

Other: \_\_\_\_\_

**For severe hypersensitive reaction, stop infusion, administer epinephrine Autoinjector IM - may repeat in 20 minutes if needed. Call 911.**

**8 PHYSICIAN SIGNATURE** (Required)

<p>X _____ PRODUCT SUBSTITUTION PERMITTED</p>	<p>_____ Date of Signature</p>		<p>X _____ DISPENSE AS WRITTEN</p>	<p>_____ Date of Signature</p>
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