

HEREDITARY ANGIOEDEMA (HAE) PRESCRIPTION FORM

1 PATIENT INFORMATION

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 CATHETER ACCESS AND FLUSH PROTOCOL (If Applicable)

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

4 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 injection)	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® (Ivanide) injection	300 mg	<input type="radio"/> Administer subcutaneously every 2 weeks (bi-weekly) <input type="radio"/> Administer subcutaneously once monthly (monthly)	28 Days	<input type="radio"/> 2 pre-filled syringes (biweekly) <input type="radio"/> 1 pre-filled syringe (monthly)	13

5 PHYSICIAN SIGNATURE (Required)

X _____ Date of Signature X _____ Date of Signature
 PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN

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6 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.

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