Orsini
Rare Disease Pharmacy Solutions

Fax: 877.277.7318 **Phone:** 800.356.4252

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	**0.9% Saline Flush:** **Dispense:** 30 Days **Refills:** PRN x 1yr Flush line/port with 10mL for patency/SASH protocol.
◯ 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.

5 PRESCRIPTION INFORMATION Please check the following:

MEDICATION	DOSE	DIRECTIONS	DAY SUPPLY	QUANTITY	REFILLS
☐ BERINERT® (C1 Esterase inhibitor [human])	_____ 20 IU/kg	_____ _____	_____	_____	_____
☐ CINRYZE® (C1 esterase inhibitor [human])	_____ max 100 IU/kg up to 2500 IU	_____ _____	_____	_____	_____
☐ FIRAZYR® (icatibant) injection ☐ 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.	_____	_____	_____
SAJAZIR™ (icatibant)	To prescribe SAJAZIR™ (icatibant), please download the enrollment form from **orsinispecialtypharmacy.com/sajazir**.				
☐ HAEGARDA® C1 Esterase Inhibitor Subcutaneous [human])	_____ max 60 IU/kg	_____ _____	28 Days	☐ 2000 IU #of vials ____ ☐ 3000 IU #of vials ____	13
☐ 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	_____
☐ RUCONEST® (C1 esterase inhibitor [recombinant])	_____ 50 IU/kg max. 4200 units	_____ _____	_____	_____	_____
☐ TAKHZYRO® (lanadelum-ab-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 _____ _____

PRODUCT SUBSTITUTION PERMITTED Date of Signature

X _____ _____

DISPENSE AS WRITTEN Date of Signature

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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, adminster 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)

X _____ _____ X _____ _____

PRODUCT SUBSTITUTION PERMITTED | Date of Signature | DISPENSE AS WRITTEN | Date of Signature