Fax: 877-277-7318 Phone: 800.356.4252

Orsini Specialty Pharmacy

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

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.

4 PRESCRIPTION INFORMATION Please check the following:

MEDICATION	DOSE	DIRECTIONS	DAY SUPPLY	# OF VIALS	REFILLS
BERINERT® (C1 Estrase inhibitor [human])	______ Units (max 20 IU/kg up to 2500 IU)	______	______	______	______
CINRYZE® (C1 esterase inhibitor [human])	______ Units (max 10 IU/kg up to 2500 IU)	______	______	______	______
FIRAZYR® (Icatibant injection)	______ Units (30 mg prefilled syringe)		______	______	______
HAEGARDA® C1 Esterase Inhibitor Subcutaneous [human]) 60u/kg	______ Units	______	28 Days	☐ 2000 IU #of vials ____ ☐ 3000 IU #of vials ____	13
RUCONEST® (C1 esterase inhibitor [recombinant])	______ Units (50 IU/kg max. 4200 units)	______	______	______	______
TAKHZYRO® (lanadelum-ab-flyo) injection	______ Units (300 mg)	administer every 2 weeks (bi-weekly) administer once monthly (monthly)	28 Days	4 vials (bi-weekly) 2 vials (monthly)	13

5 PHYSICIAN SIGNATURE *(REQUIRED)*

X ______________________ PRODUCT SUBSTITUTION PERMITTED ________ Date of Signature

X ______________________ DISPENSE AS WRITTEN ________ Date of Signature

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6 TREATMENT REGIMEN

Administer pre-medication 30-60 min prior to drug infusion

PRE-MEDICATION

- ☐ Antipyretic: ______________________ **Qty:** 6 month **Refills:** PRN x 1yr
- ☐ Antihistamine: ______________________ **Qty:** 6 month **Refills:** PRN x 1yr
- ☐ EMLA (Lidocaine 2.5%/Prilocaine 2.5%) or ☐ LMX4 cream (Lidocaine 4%) **Qty:** 30 Gram **Refills:** PRN x 1yr ☐ Other: ______________
  Apply 1-2 hours before port access.

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
2. Mix ______________ according to package insert (main recommendation)
3. Infuse ______________ via IV push over ______________

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 Epi-Pen® or equivalent.
If severe symptoms persist, may repeat. **(Please select Epi-Pen® dose):**

Epi-Pen 0.3 mg autoinjector IM (patients >30 kg)
Epi-Pen Jr. 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 Epi-Pen®/Epi-Pen Jr Autoinjector IM - may repeat in 20 minutes if needed. Call 911.

8 PHYSICIAN SIGNATURE *(REQUIRED)*

X ______________________ ____________
PRODUCT SUBSTITUTION PERMITTED Date of Signature

X ______________________ ____________
DISPENSE AS WRITTEN Date of Signature

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