ameripharma SPECIALTY CARE

Hereditary Angioedema

Phone#: 877-778-0318 Fax#: 877-778-0399

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ Male ☐ Female SSN: _____ Wt (kg/lbs): _____ Ht (cm/in): _____

Address: _____ Phone: _____ Alternate: _____

Emergency Contact: _____ Relation to Patient: _____ Phone: _____ Alternate: _____

Allergies: _____

Insurance Information

Primary Insurance: _____ Subscriber Name: _____

ID Number: _____ RxBIN#: _____ RxGroup#: _____ RxPCN#: _____ Insurance Phone #: _____

Secondary Insurance: _____ Subscriber Name: _____

ID Number: _____ RxBIN#: _____ RxGroup#: _____ RxPCN#: _____ Insurance Phone #: _____

Medical Necessity

☐ D84.1 Date of Diagnosis: _____ ☐ Other ICD-10: _____ Description: _____

☐ Pregnancy Due Date: _____ Frequency of Attacks: _____

Type: ☐ Type 1 ☐ Type 2 ☐ Unknown

Lab Confirmation: ☐ C1 Level ☐ C4 Level ☐ No

Location: ☐ Facial ☐ Laryngeal ☐ Abdominal ☐ Urogenital ☐ Extremity

Days of missed work/school per year: _____

Vaccinations: ☐ Hepatitis B Date: _____ ☐ Influenza Date: _____ ☐ Pneumoccocal Date: _____

Anticipated surgeries: ☐ Yes ☐ No Date: _____

Site of Care / Shipping Information

☐ Physician Office

☐ Infusion Suite

☐ Home Health Agency *(preferred agency)*: _____

☐ Request training for self-injection for Firazyr®

☐ Other: _____

Ship to: ☐ Patient ☐ MD Office ☐ Other: _____

NEED BY DATE: _____

Other current HAE medications: _____

Prescription	Strength	Directions	Quantity	Refills
☐ **Firazyr®**	☐ 30 mg/3 mL ☐ 1 - syringe pack ☐ 3 - syringe pack	Inject 30mg subcutaneously into abdominal area. If response is inadequate or symptoms recur, additional injections of 30mg may be administered at 6 hour intervals with a maximum of 3 doses within 24 hours.		

Prescriber

Prescriber's Full Name: _____ DEA #: _____ NPI #: _____ License #: _____

Hospital / Clinic: _____ Phone Number: _____

Address: _____ Fax Number: _____

Office Contact: _____ Medicaid Number: _____

Prescriber's Signature: _____ Date: _____

I authorize AmeriPharma and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to AmeriPharma.

Reset Form