

FAX FORM TO: 1.877.597.3070

PHONE: 1.800.473.3516

EMAIL: specialty@wellpartner.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION	
Name:	
Address:	
City, State, ZIP:	
Primary Phone: - -	DOB: / /
Alternate Phone: - -	Gender:
Email:	
Primary Language:	Last Four of SSN:

2. PRESCRIBER INFORMATION	
Name:	
DEA #:	NPI #: State Lic. #:
Group or Hospital:	
Address:	
City, State, Zip:	
Phone: - -	Fax: - -
Contact Person:	Phone: - -

3. INSURANCE INFORMATION *Fax copy of prescription and insurance cards with this form, if available (front and back)*

Primary Insurance Company Name:	Secondary Insurance Company Name:
Primary Cardholder Name:	Secondary Cardholder Name:
Relationship: <input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child/Dependent	Relationship: <input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child/Dependent
Phone: - - Member ID: Group #:	Phone: - - Member ID: Group #:

4. DIAGNOSIS AND MEDICAL NECESSITY

Needs by Date: / /	Ship to: <input type="radio"/> Patient <input type="radio"/> Office <input type="radio"/> Other:
Date of Diagnosis: / /	Is patient pregnant? <input type="radio"/> Yes <input type="radio"/> No If yes, due date: / /
<input type="radio"/> D84.1 Defects in the complement system	Frequency of attacks: Severity of attacks: <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe
<input type="radio"/> Other:	Location of attacks: <input type="radio"/> Facial <input type="radio"/> Laryngeal <input type="radio"/> Abdominal <input type="radio"/> Extremity <input type="radio"/> Urogenital
Type: <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Unknown	Days of incapacitation per year:
Lab Confirmation: <input type="radio"/> C1 level <input type="radio"/> C4 level <input type="radio"/> None	Port? <input type="radio"/> Yes <input type="radio"/> No
Height (in/cm): Weight (lb/kg):	Any anticipated surgeries? <input type="radio"/> Yes <input type="radio"/> No If yes, date: / /
Date of measurement: / /	Site of care:
Allergies:	<input type="radio"/> Physician Office <input type="radio"/> Infusion Clinic <input type="radio"/> Hospital Outpatient <input type="radio"/> Home Health <input type="radio"/> Other:
Concomitant Medications:	<input type="radio"/> Request training for self-infusion <input type="radio"/> Ongoing nursing is required

5. PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
<input type="radio"/> Firazyr®	30 mg/3 ml <input type="radio"/> 1- syringe pack <input type="radio"/> 3- syringe pack	Inject SQ in abdominal area. If response is inadequate or symptoms recur, additional injections of 30 mg may be administered at 6 hour intervals with a max of 3 doses in 24 hours.		
<input type="radio"/> Berinert (LD)*	(LD)* These are limited distribution drugs that require additional handling. Please call (1.800.473.3516) for more information.			
<input type="radio"/> Cinryze (LD)*				
<input type="radio"/> Kalbitor (LD)*				
<input type="radio"/>				
<input type="radio"/>				

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE

X	/ /	X	/ /
DISPENSE AS WRITTEN	DATE	PRODUCT SUBSTITUTION PERMITTED	DATE

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address or telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.