elixir
SPECIALTY PHARMACY

Enzyme Replacement Therapy/Hereditary Angioedema Enrollment Form

Phone: 877-437-9012 Fax: 877-309-0687

☐ New to Therapy
☐ Current Therapy

Customer Information

Customer Name: _____
Date of Birth: _____ Sex: M☐ or F☐ Caregiver:_____
Address: _____
City: _____State:_____Zip:_____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-mail:_____
Please attach copy of front and back of customer's prescription insurance card(s) if applicable
Insurance Company Name: _____
Insurance Company Phone: _____
Policy holder:_____
Policy holder Employer:_____
Relationship to Customer:_____
ID# _____Group#_____
RxBIN: _____RxPCN:_____
Copay Card:

Prescriber Information

Practice/ Organization Name: _____
Prescriber Name:_____
Address:_____
City: _____State: _____ Zip: _____
Phone#:_____Fax#:_____
DEA#_____NPI#_____
License#:_____Medicaid UPIN#:_____
Physician Specialty: _____
Prior Authorization Information: ☐ Please fax PA forms ☐ PA started
☐ PA has been approved, auth #: _____
☐ Other: _____
Date Shipment Needed: _____
Ship to: ☐ **Patient** ☐ **Prescriber** ☐ **Other:**_____
Shipment Address: _____Attn: _____
City: _____State: _____Zip:_____
If shipped to the prescriber's office,Prescriber accepts on behalf of patient for administration in office.
Current Nursing Agency or indicate if nursing needs set up: _____
_____

Clinical Information and Prescription

Primary Diagnosis (ICD10): ☐ _ _ _ . _ _ Description: _____
Secondary Diagnosis (ICD10): ☐ _ _ _ . _ _ Description: _____
Height: _____inches/cm Weight: _____lb/kg Date of Measurement: ___/____/_____
Allergies: _____
Has the patient tried and failed other products? ☐ Yes _____ ☐ No
Current Medications: _____
_____
Vascular Access: ☐ Peripheral IV ☐ Port-a-cath ☐ PIC ☐ Central line ☐ Other: _____
Administration by: ☐ Patient ☐ Caregiver ☐ Nursing Agency ☐ Other: _____
Agency nurse to visit home for injection: ☐ No ☐ Yes: Agency Name / Phone: _____
Date of First/Next Injection: ____/____/_____ **Date of Last Injection:** ____/____/_____
Pump: ☐ Need to rent from Elixir ☐ Patient owns a pump ☐ Other: _____
Pump Type: _____ Serial Number: _____ Other: _____

☐ **Enzyme Replacement Product:** ☐ Cerezyme ☐ Fabrazyme ☐ Elaprase
☐ Cerdelga ☐ Zavesca* (866-ACTELION to order) ☐ Elelyso* (855-ELELYSO to order) ☐ VPRIV
☐ Galafold* (833-AMICUSA to order) ☐ Other: _____
☐ **HAE Product**: ☐ Icatibant (Firazyr) ☐ Berinert (C1 inhibitor, human)
☐ Ruconest* (855-613-4HAE to order) ☐ Cinryze* (866-888-0660 to order) ☐ Haegarda* (844-HAEGARDA to order) ☐ Kalbitor* (866-888-0660 to order) ☐ Other: _____

Route of Administration: ☐ IV ☐ SC ☐ IM
Write "DAW" here if needed: ☐
Directions: _____
Infusion Rate:_____
Flush Protocol: _____

Ancillary medications:

Drug	Strength	Directions	Quantity	Refills
Diphenhydramine				
Acetaminophen				
EpiPen / EpiPen Jr.	0.3mg / 0.15mg	Inject IM/SQ into thigh, repeat after 5 to 20 minutes if needed for anaphylaxis		

Supplies requested: _____
_____
_____

Refills Authorized: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 6 mos ☐ 1 yr ☐ Other: _____
Prescriber Signature: *X*_____ Date: ____/____/____

Privacy & Confidentiality of Information Notice: This communication may contain non-public, confidential, or legally privileged information intended for the sole use of the designated recipient(s). If you are not the intended recipient, or have received this communication in error, please notify the sender immediately by reply email or by telephone at the number stated above and delete all copies of this communication, including any attachments, without reading them or saving them to disk. If you are the intended recipient, you must secure the contents of this communication in accordance with all applicable state or federal requirements related to the privacy and confidentiality of information, including the HIPAA Privacy guidelines.