Hereditary Angioedema Enrollment Form

NOBLE
HEALTH SERVICES
A SPECIALTY PHARMACY
Signature Care Program

☐ **Noble Syracuse**
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www.noblehealthservices.com

Delivery Need By: _____   Delivery to: ☐ Patients Home ☐ Physician's Office ☐ Other

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: ☐ Female ☐ Male	Prescriber Name:
Address:	Address:
City, State, Zip: _____ , _____ ,	City, State, Zip: _____ , _____ ,
Phone:	Phone:
Date of Birth:	Fax:
Last four of Social Security Number:	DEA/NPI#:

INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis/ ICD-10 Code:	Has the patient been treated previously for this condition? ☐ Yes ☐ No
Height: ____ feet ____ inches Weight: ____ lbs.	Medications failed:
Allergies:	Medications on:
Other notes:	

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Firazyr®	☐ 30 mg/3 ml Syringe	☐ Administer 30mg (contents of one syringe) via subcutaneous injection in the abdominal area over at least 30 seconds for an acute attack of Hereditary Angioedema. If the response is inadequate or symptoms recur, additional injections of 30 mg may be administered at 6 hour intervals with a maximum of 3 doses in 24 hours.	☐ ____ 30 mg doses. Keep at least three 30 mg doses on hands at all times (Unless noted, ____ doses)	
Other:				

☐ Patient is interested in patient support programs   ☐ Ancillary supplies provided for administration

Office Contact Name: _____ Preferred Phone Number & Extension: _____

Physician Signature: _____ Date: _____

E-Scribe Rx and Fax this Form