ECALLANTIDE (KALBITOR®) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:

YOUR INTELLIGENT HEALTH COMPANY. UBACARE	**Patient Name:**			**Date of Birth:**	
	Address:				
	Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs. ☐ kg

Clinical Information

Primary Diagnosis Description: Defects in the complement system (hereditary angioedema) | **ICD-10 Code:** D84.1

Ecallantide (Kalbitor®) Prescription

Ecallantide (Kalbitor®) 30 mg (3 x 10 mg/mL vials) refill as directed x 1 year

Inject a total dose of 30 mg SQ as 3 x 10 mg (1 mL) SQ injections PRN acute HAE attack.

If no response in 45 to 60 minutes after initial dose, an additional total dose of 30 mg SQ may be administered.

If no response in 45 to 60 minutes after the second dose, call the prescriber.

Dispense _____ doses.

Keep _____ doses on-hand at all times.

Ancillary Orders

Anaphylaxis Kit

➔ Required per Option Care Health policy – please complete Anaphylaxis Physician Order (FR-PC-036) provided.

Pre-Medication Orders

☐ Other: _____

Skilled nurse to administer doses SQ as ordered. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name:		**Phone:**	**Fax:**
Address:		**NPI:**	
City, State:	**Zip:**	**Office Contact:**	

