

# ICATIBANT 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

## Icatibant Prescription

Icatibant 30 mg/3 mL syringe refill as directed x 1 year

Inject 30 mg SQ in the abdomen over 30 seconds PRN acute HAE attack.

If no response or symptoms recur, repeat with an additional 30 mg SQ every 6 hours PRN – do not exceed 3 doses in 24 hours.

Dispense \_\_\_\_\_ doses.

Keep \_\_\_\_\_ doses on-hand at all times.

A generically equivalent drug product may be dispensed unless the practitioner hand writes "Brand Medically Necessary" or "Do Not Substitute" to dispense Firazyr®:

\_\_\_\_\_

## Ancillary Orders

### Pre-Medication Orders

Other: \_\_\_\_\_

Skilled nurse to assess and teach administration of medication by patient and/or caregiver if patient not yet independent. 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:

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