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:**	

