Berinert® Referral Form (C1 Esterase Inhibitor, Human)

140 Northway Court
Raleigh, NC 27615
www.medprorx.com

Phone 1-888-571-3100
Fax 1-800-582-9315

DEMOGRAPHICS

Patient Name:		**Sex**: M F	**DOB**:
Phone (H):	**Phone (W)**:		**SS#**:
Address:	**City**:	**State**:	**Zip**:

INSURANCE INFORMATION

(Please provide a copy of the front and back of the insurance card or complete the fields below)		
Primary Insurance:		**Phone**:
Subscriber Name:		**DOB**:
Employer:	**Group/Policy #**:	**ID #**:
Secondary Insurance:		**Phone**:
Subscriber Name:		**DOB**:
Employer:	**Group/Policy #**:	**ID #**:
*Check here if physician would like to be contacted with insurance information **prior** to pharmacy contacting the patient.*		

PHYSICIAN INFORMATION

Name:	NPI:		UPIN:
Phone:	Fax:		
Address:	City:	State:	Zip:

MEDICAL INFORMATION

Diagnosis Related to Therapy: Hereditary Angioedema **ICD-9:** 277.6

History:	Coronary Artery Disease	Diabetes (Type 1)	Diabetes (Type 2)	Hypertension	
	Previous MI, DVT, TIA	Smoker	Migraine	Overweight	
	Renal Disease	Other (specify):	kg **Allergies**:		
Height: inches	**Weight**: lb				

PRESCRIPTION INFORMATION

PRESCRIPTION **Drug:** BERINERT® **Dose:** 20 U/kg Other:

Dispense qty: 2 doses 3 doses Other: **# Days Supply:**

Refill qty: 1 year (unless otherwise directed) or Other:

Rate: Infusion per manufacturer's guidelines Other (specify):

Anaphylaxis Kit: EpiPen 2-Pack® (or equivalent) as directed for anaphylaxis

VENOUS ACCESS	**Route of administration:** IV			**Type:**	PICC	Tunneled central venous line
	Patient to be taught self-infusion?	Yes	No		Port	Peripheral IV

Nursing services requested? Yes No **Flush orders:** **per MedPro Rx protocol PRN**

MD Signature _____ **Date** _____