

KALBITOR Access start form

In order for your patient to receive KALBITOR Access services, complete and fax this form, along with the signed KALBITOR Access Patient Authorization, to 1-888-806-4829.

<i>Note: This form cannot be processed unless all bolded fields are completed.</i>			
PATIENT INFORMATION			
Patient's Last name:		Patient's First Name:	
Patient's Middle Name:			
Date of Birth: / /	Social Security no. (last 4 digits):	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Other: _____
Street Address:		City:	State: ZIP Code:
Primary phone no. (home/cell): () <input type="checkbox"/> Preferred?	Secondary Phone no. (home/cell): () <input type="checkbox"/> Preferred?	Work phone no.: () <input type="checkbox"/> Preferred?	Email Address:
Alternate Contact/Caregiver:	Relationship to Patient:	Phone no.:	Email address:
PATIENT INSURANCE INFORMATION (please leave blank if no insurance)			
Primary Insurance Company:		Policy Number/ID Number:	Group Number: Ins. Company Phone: ()
Subscriber Name (please include first and last):		Subscriber Date of Birth: / /	
Secondary Insurance Company:		Policy Number/ID Number:	Group Number: Ins. Company Phone: ()
Subscriber Name (please include first and last):		Subscriber Date of Birth: / /	
PRESCRIBER INFORMATION			
Prescriber Name (Last, First):		Practice Name:	Specialty:
Tax ID Number:	NPI Number:	License Number:	DEA Number:
Street Address:		City:	State: ZIP Code:
Phone no.: ()	Fax no.: ()	Email Address:	
Office Contact:	Office Contact Phone no.:	Office Contact Fax no.:	Office Contact Email Address:
DIAGNOSIS AND CLINICAL INFORMATION			
Primary Diagnosis: ICD-9 277.6	Hereditary Angioedema <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Unknown Type	Date of Diagnosis: / /	
Clinical Notes:			
KALBITOR PRESCRIPTION			
Prescription Type: <input type="checkbox"/> New Start <input type="checkbox"/> Continued Treatment		Drug Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> Drug Allergies: _____	
Prescription: Dispense KALBITOR 30 mg subcutaneously PRN for treatment of acute attacks of Hereditary Angioedema (HAE). Dispense 2 dose supply.			
Refill: _____ Times	Refill through: / /		
Ship To Address: <input type="checkbox"/> Same as Office Address Above <input type="checkbox"/> Different address below [Note: Product CANNOT be shipped directly to the patient]			
Street Address:		City:	State: ZIP Code:
PHYSICIAN SIGNATURE			
By signing below, I certify that (a) the above therapy is medically necessary, (b) I have received the necessary authorization to release the above referenced information and other protected health information (as defined in the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) to Dyax Corp., KALBITOR Access program staff and contracted dispensing pharmacy or other contractors for the purpose of seeking reimbursement, assisting in initiating or continuing therapy and/or the evaluation of the patient's eligibility for financial assistance program, (c) I will not sell or bill for any free product received in my office for patients from the KALBITOR Patient Assistance Program, (d) I appoint the KALBITOR Access program solely to convey on my behalf to the pharmacy dispensing the above named patient's prescription described herein, (e) I have reviewed the KALBITOR Medication Guide with the patient named on this Start Form.			
X Prescriber Signature:			Date:

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KALBITOR Access Patient Authorization on following page →

Call 1-888-4KALBITOR (1-888-452-5248) to reach a KALBITOR Access specialist.

healthcare provider to complete

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