

1 Patient Demographic & Health Insurance Information

demographic information

Last Name: _____ First Name: _____ Middle Name: _____
 Date of Birth: _____ Social Security Number (last 4 digits): _____ Gender: M F Preferred Language English Other: _____
 Street Address: _____ City: _____ State: _____ ZIP Code: _____
 Home #: _____ Work #: _____ Cell #: _____ Email Address: _____ Best Time to Contact: _____
 Alternate Contact/Caregiver: _____ Relationship to Patient: _____ Phone: _____

health insurance information

Patient does not have health insurance _____
 Primary Health Insurance Company: _____ Policy/ID Number: _____ Group Number: _____ Ins. Company Phone: _____
 Subscriber Name (please include first and last): _____ Subscriber Date of Birth: _____
 Secondary Insurance Company: _____ Policy/ID Number: _____ Group Number: _____ Ins. Company Phone: _____
 Subscriber Name (please include first and last): _____ Subscriber Date of Birth: _____
 Prescription Drug Insurer _____ Rx Bin: _____ Rx ID Number: _____ Rx Group Number: _____
 Rx PCN: _____ Rx Pharmacy Help Desk Phone: _____

2 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: _____ Fax: _____ Email Address: _____
 Hospital Affiliations: _____
 Primary Office Contact: _____ Office Contact Phone #: _____ Office Contact Email Address: _____

3 Diagnosis Information & Statement of Medical Necessity

Primary Diagnosis: ICD-9 277.6 Other deficiencies of circulating enzymes; hereditary angioedema _____ Hereditary Angioedema Type 1 Type 2 Unknown Type Date of Diagnosis: _____
 Diagnosis Confirmed Through Lab Testing: C1 level C4 level No _____ Frequency of Attacks (total number over the last 12 months): _____
 yes _____ Other Current HAE Medications: _____

4 KALBITOR Prescription & Shipment Location

Prescription Type: New Start Refill Drug Allergies: _____ NDC: 47783-0101-01 Refill: _____ Times

Prescription: Dispense KALBITOR 30 mg (administered as 3 separate 1-mL subcutaneous injections) for PRN treatment of acute attacks of hereditary angioedema (HAE). Dispense 2 dose supply.

By signing below, I certify that (a) the above therapy is medically necessary, (b) I appoint Dyax or its designee to convey on my behalf to the pharmacy dispensing the above-named patient's prescription described herein, (c) I appoint Dyax or its designee to convey on my behalf orders to a home infusion service provider to provide home infusion services for the above-named patient, (d) I acknowledge that Dyax will not provide home infusion services, and (e) I have reviewed the KALBITOR Medication Guide with the patient named on this form.

X _____ Date: _____

Please see accompanying Full Prescribing Information including Boxed Warning for anaphylaxis.
 * KALBITOR Home Infusion ServicesSM are administered by a third-party infusion service provider.