HAEGARDA Connect℠ QuickStart Program

QuickStart Form must be submitted to HAEGARDA Connect with a completed HAEGARDA Referral Form.

HAEGARDA®
C1 Esterase Inhibitor Subcutaneous (Human)

Fax completed form to 1-866-415-2162 **Phone** 1-844-HAEGARDA (1-844-423-4273)

Healthcare Provider Information *(REQUIRED)*

Prescriber name		Facility name		
Address		City	State	Zip
Office contact	Office phone #	Office fax #	Email	
State license #	NPI #	Tax ID	DEA	PTAN

Prescription Information *(REQUIRED)*

Ship to: ❑ Patient's Home ❑ Healthcare Provider *(Drug cannot be shipped to any inpatient facility.)*

Patient name	DOB	Weight *(Specify kg or lbs)*	❑ kg ❑ lbs	
Address		City	State	Zip

HCP facility name *(Complete if shipping to an HCP address different from above)*

Address		City	State	Zip
Office contact	Office phone #	Office fax #	Email	

Date of most recent therapy	Drug allergies

Dosing of HAEGARDA: 60 IU/kg twice weekly
HAEGARDA is available in 2000 IU and 3000 IU vials. No exceptions to dosing quantity.

Administer _____ units of HAEGARDA subcutaneously twice weekly (every 3 or 4 days).
Pharmacy to include ancillary supplies.
First dispense to include HAEGARDA and ancillary supplies for 14 day fill.

Refills: Patient may receive up to 2 additional months of QuickStart. Refill dispenses will only be dispensed in a 14 day supply of HAEGARDA with ancillary supplies. Not all patients will be eligible for refills. Refills are only authorized in the event of a delay in commercial therapy.

Site of Care: ❑ Home ❑ Facility

Directions

Special instructions

Special precautions

Nurse-facilitated self infusion training to support the QuickStart Program is available upon completion of nursing orders located on the HAEGARDA Referral Form.

Prescriber Attestation *(REQUIRED)*

By signing and dating, I attest that the person listed is my patient for whom I have prescribed a CSL Behring product in accordance with the labeled use of the product. I acknowledge that this patient is applying for therapy assistance and does not have access to commercially available CSL Behring product at this time. I acknowledge and agree not to submit a third-party insurance claim or other claim for payment for this product or for services rendered in association with its administration, including Medicare Parts A, B, and D, Medicare Advantage Plans, Medicaid, Medicaid Managed Care, Veterans Administration (VA), TRICARE, State Children's Health Insurance Plans (SCHIPS), and Preexisting Condition Insurance Plans (PCIPs). Furthermore, I acknowledge that CSL Behring reserves the right, in its sole discretion, to discontinue at any time its QuickStart Program provision of product to this patient. I certify that I have received the necessary authorization from the patient to release the medical and/or patient information on this form to CSL Behring and its contracted agent or contractors, working solely on behalf of the patient, for the purpose of participating in the HAEGARDA QuickStart Program.

Prescriber Signature SIGN HERE _____ Date *(REQUIRED)* _____

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www.CSLBehring.com **www.HAEGARDA.com** HGD-0254-JAN23

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