Reset Form

firazyr® (icatibant injection)

OnePath® Start Form: Authorization for OnePath Services

Phone: 1-866-888-0660 Fax: 1-855-ONEPATH (663-7284)

OnePath®

1 Prescribing Physician Information

Name (First, Last) _____ Site Name _____

Street Address _____ City _____ State _____ Zip Code _____

(_____) _____ Telephone (_____) _____ Fax _____ Office Contact

State License # _____ National Provider ID # _____

2 Patient Information

Name (First, Middle Initial, Last) _____ ☐ Male ☐ Female

DOB: Month/Day/Year _____ Age (years) _____ Last 4 digits of Social Security # _____ Email Address _____

Street Address _____ City _____ State _____ Zip Code _____

(_____) _____ Home Telephone (_____) _____ Mobile Telephone (_____) _____ Work Telephone

Caregiver Name (First, Last) _____ Relationship to Patient _____ (_____) _____ Caregiver Telephone

3 Insurance Information

Please attach copies of both sides of patient's insurance card(s) ☐ **Check if patient does not have insurance**

Primary Insurance _____ (_____) _____ Insurance Telephone

Policy ID # _____ Group # _____ Policy Holder Name (First, Last) and Relationship to Patient _____

Pharmacy Plan Name _____ (_____) _____ Pharmacy Plan Telephone

Policy ID # _____ Group # _____ Rx Bin # _____ Rx PCN # _____

Secondary Insurance _____ (_____) _____ Insurance Telephone

Policy ID # _____ Group # _____ Policy Holder Name (First, Last) and Relationship to Patient _____

4 FIRAZYR Prescription, Training Request/Waiver, and Prescribing Physician Signature

Prescription: FIRAZYR® (icatibant injection) ☐ **ICD-10 D84.1 (HAE)** ☐ **Other:** _____

Dose: **One (1) subcutaneous injection 30 mg**

Directions: **Administer one 30-mg subcutaneous injection in the abdominal area**

Dispense: ☐ **Three (3) syringes (NDC 54092-702-03)** ☐ **One (1) syringe (NDC 54092-702-02)** **Refill:** _____

Special Instructions: _____

Special Precautions (eg, allergies): _____

I appoint Shire, Human Genetic Therapies, Inc., its affiliates and their representatives (collectively "Shire") to convey on my behalf the prescription described herein to a pharmacy, if applicable.

Training Request/Waiver (check one box below):

☐ **YES**, please provide my patient and/or his/her caregiver with training on the proper self-administration of FIRAZYR.

☐ **NO**, I or another health care provider have trained the patient and/or caregiver on the proper self-administration of FIRAZYR.

Prescriber Signature: _____ **Date:** _____

(stamps not acceptable) **DISPENSE AS WRITTEN**

5 Patient Authorization to Share Personal Health Information and OnePath Enrollment

Patient Authorization to Share Personal Health Information

I authorize any health plan, physician, health care professional, hospital, clinic, pharmacy provider or other health care provider (collectively, "Health Care Providers") to disclose my personal health information, including information relating to my medical condition, treatment, care management, and health insurance, as well as all information provided on this form and any prescription, personal health information obtained by Health Care Providers prior to the date of this authorization ("Personal Health Information"), to Shire, Human Genetic Therapies, Inc., its affiliates and their representatives, agents, and contractors (collectively, "Shire") and to receive financial remuneration from Shire in exchange, for the following purposes: for Shire to provide product support services, including coordination of benefits and therapy; reimbursement support; investigating insurance coverage; communicating with me by mail, email, or telephone about my medical condition, treatment, care management, and health insurance; and internal use by Shire, including data analysis. I understand that my Personal Health Information disclosed under this authorization may be re-disclosed by Shire and no longer protected by federal privacy laws. I understand, however, that Shire agrees to undertake reasonable efforts to maintain my Personal Health Information in a secure manner and not to disclose it to third parties without a legitimate reason for doing so. I understand that I may refuse to sign this Authorization and that my treatment, payment, enrollment or eligibility for benefits, including my access to therapy, is not conditioned on my signing this Authorization. I understand that I am entitled to a signed copy of this Authorization. This Authorization expires one year from the date of execution, or one year after the date of my last prescription, whichever is later. I understand that I may revoke this Authorization at any time by sending written notice of revocation to OnePath, 300 Shire Way, Lexington, MA 02421, which becomes effective upon receipt by any Health Care Provider subject to federal privacy laws, except to the extent that action already has been taken in reliance on this Authorization.

OnePath Enrollment *(must check box below to be enrolled in product support services through OnePath)*

☐ I certify that all of the information provided on this form is complete and accurate. I authorize Shire to collect Personal Health Information from me, my caregivers, and Health Care Providers, and to use and disclose such Personal Health Information to provide product support services, including but not limited to coordination of benefits and therapy; reimbursement support; investigating insurance coverage; communicating with me by mail, email, or telephone about my medical condition, treatment, care management, and health insurance.

Patient Signature: _____ **Date:** _____

(If patient is a minor)

Parent/Guardian Signature: _____ **Date:** _____

FIRAZYR® (icatibant injection) is indicated for the treatment of acute attacks of hereditary angioedema (HAE) in adults 18 years of age and older.
FIRAZYR clinical trials evaluated patients with only Type 1 or Type 2 HAE. Please see full Prescribing Information available from Shire representative or at firazyr.com.

ADDITIONAL GUIDANCE FOR COMPLETION OF FORM

1 Prescribing Physician Information, 2 Patient Information, and 3 Insurance Information

- Fill out completely
- Do not submit to Shire any documentation of labs, clinical history, or other documents supporting the prior authorization process

4 FIRAZYR Prescription, Training Request/Waiver, and Prescribing Physician Signature

- FIRAZYR® (icatibant injection) is dispensed in 2 ways (please check 1 option): 3 syringes or 1 syringe
- Please indicate the number of refills
- Check the appropriate box to specify whether you would like your patient to be trained by Shire on proper self-administration or whether training has already occurred
- This is a prescription; a physician's signature and date are required

5 Patient Authorization to Share Personal Health Information and OnePath Enrollment

- The patient signature is required to allow personal health information to be shared by third parties to Shire to facilitate access to FIRAZYR (insurance benefits, self-administration training, transfer Rx to Specialty Pharmacy Provider, etc.)
- **Checking the OnePath Enrollment box allows patients to receive product support services from Shire, if eligible**
  - Benefits investigation
  - Injection training (if applicable)
  - Co-pay support (when applicable) and information about third-party financial assistance programs, as necessary
  - Enrollment in OnePath–Patient Support Manager assignment and product support services

WHAT HAPPENS NEXT?

- Once the completed form has been submitted to OnePath®, a dedicated Patient Support Manager will be assigned to your eligible patient
- The Patient Support Manager will contact the patient directly to inform him or her of the services available through OnePath and to begin the insurance verification process
- The Patient Support Manager will work with the insurance company to determine insurance benefits
  - If applicable, OnePath will assess the patient's eligibility for co-pay support and any other means that will assist the patient in accessing FIRAZYR
- If requested, the Patient Support Manager will set up Shire-provided self-administration training services

Shire

firazyr® (icatibant injection)