

**1. Prescription**

**Preferred Specialty Pharmacy:**

Accredo  CVS Caremark  Option Care  Orsini

Patient Name .....

DOB .....

ICD-10-CM D84.1 (HAE)  Other .....

Prescription: RUCONEST 2100 IU/vial injection (50 IU/kg)

**DIRECTIONS:** Administer ..... IU (max 4200 IU) as a slow IV injection over 5 minutes prn for attacks. No more than 2 doses within a 24-hour period

**Doses Per Shipment**

4 doses (8 vials)  8 doses (16 vials)  
 16 doses (32 vials)  ..... doses (..... vials)

**Refill x 1 year unless noted otherwise**

3 Refills  6 Refills  12 Refills  ..... Refills

**Day Supply** (How frequently do you want the patient to fill the Rx)

1x month  1x a week  as needed

**SPECIAL INSTRUCTIONS**

Drug/Non-Drug Allergies .....  No Known Allergies Concurrent Medications .....

MD Sign

Dispense as written **PRESCRIBER** ..... Print ..... Date .....

Substitution permitted **PRESCRIBER** ..... Print ..... Date .....

I appoint Pharming Healthcare, Inc., RUCONEST SOLUTIONS, its affiliates, and their representatives on my behalf to convey this prescription described herein to the dispensing pharmacy. I understand that I may not delegate signature authority.

**Dispense infusion supplies with each prescription**

**Dispense: One (1) vial of Sterile Water for Injection 14 mL per 2100 IU vial of RUCONEST**

**Flushing Orders**

Normal saline 3 mL or 5 mL intravenous (peripheral line) or 10 mL intravenous (central line) before and after infusion, or as needed for line patency  
 Heparin 10 units/mL (#3mL or #5mL) use as a final flush for peripheral line (QS)  
 Heparin 100 units/mL (#3mL or #5mL) use as a final flush for central line (QS)

**Anaphylaxis Order** Specialty pharmacy to provide anaphylactic kit per provider protocol. Substitution permitted unless DAW specified.....

**Epinephrine #2 pack**  0.15mg or  0.3mg **Refills:** .....  
 Inject SQ or IM as needed for anaphylaxis reaction times one dose.  
 May repeat x 1 in 5 to 15 minutes if symptoms persist. SP to provide at first dispense.

**2. Optional Prescription for Bridge to Therapy Program for RUCONEST**

Patient Name .....

DOB .....

ICD-10-CM D84.1 (HAE)  Other .....

Prescription: RUCONEST 2100 IU/vial injection (50 IU/kg)

**DIRECTIONS:** Administer ..... IU (max 4200 IU) as a slow IV injection over 5 minutes prn. No more than 2 doses within a 24-hour period

2 doses (4 vials)  ..... doses (..... vials)  Refills .....

**SPECIAL INSTRUCTIONS**

Drug/Non-Drug Allergies .....  No Known Allergies Concurrent Medications .....

MD Sign

Dispense as written **PRESCRIBER** ..... Print ..... Date .....

Substitution permitted **PRESCRIBER** ..... Print ..... Date .....

I appoint Pharming Healthcare, Inc., RUCONEST SOLUTIONS, its affiliates, and their representatives on my behalf to convey this prescription described herein to the dispensing pharmacy. I understand that I may not delegate signature authority.

**Dispense infusion supplies with each prescription**

**Dispense: One (1) vial of Sterile Water for Injection 14 mL per 2100 IU vial of RUCONEST**

**Flushing Orders**

Normal saline 3 mL or 5 mL intravenous (peripheral line) or 10 mL intravenous (central line) before and after infusion, or as needed for line patency  
 Heparin 10 units/mL (#3mL or #5mL) use as a final flush for peripheral line (QS)  
 Heparin 100 units/mL (#3mL or #5mL) use as a final flush for central line (QS)

**3. Optional Specialty Pharmacy Nursing Orders**

Skilled nursing visit as needed to provide patient education related to therapy, disease state, self and/or nurse administer of medication as prescribed. (Select 1 option below)

- Provide ongoing nursing visits for administration and education until patient/caregiver is independent with self infusion.
- Provide ongoing nursing visits for On Demand infusions, patient/caregiver unable or unwilling to learn self infusion.
- No nursing required; patient is independent with self infusion.

**Location of Skilled Nursing**

Home  
 Other .....

Visit frequency (based on medication order and dosage order) and patient's/caregiver's ability to self-administer .....

Inject epinephrine subcutaneously or intramuscularly for anaphylaxis reaction, may repeat in 5-15 minutes if no resolution. Call 911.

MD Sign

**PRESCRIBER** ..... Date .....

**4. Patient Information**

Attach copy of demographic/face sheet OR complete below

Name .....  Male  Female    SSN # .....    DOB .....

Check Preferred Phone #  Work # .....  Home # .....  Cell # .....

Email ..... Preferred Language .....

Address ..... City/State/ZIP .....

Caregiver Name (first, last) ..... Relationship to Patient .....

Phone # .....  Okay to leave vm    Caregiver email .....

**5. Patient Insurance Information**

Attach all insurance and prescription cards OR complete below

**Medical Insurance Card**

Plan Name .....

Plan Phone # .....

Policy Holder Name .....

Member ID # .....

Group # .....

**Prescription Drug Card**

PBM/Plan Name .....

Plan Phone # .....

Member ID # .....

BIN # .....

PCN # .....    Group # .....

**6. Prescriber Information**

Provider Specialty:  Allergy  Immunology  Dermatology  Primary Care  Emergency Room  Other

Provider Name ..... NPI # .....    TIN # .....

Medicaid Provider ID # ..... State License # .....    PTAN # .....

Site Name .....

Address ..... City/State/ZIP .....

Phone # ..... Fax # .....

Contact Name ..... Role .....    Phone # .....

**Please see accompanying full Prescribing Information.**

RUCONEST is a registered trademark of Pharming Intellectual Property, B.V.  
© 2018 Pharming Healthcare, Inc. RUCS-US-2018-0004 Printed in USA.

RUCONEST SOLUTIONS: 1-855-613-4423

1. I am participating in the RUCONEST SOLUTIONS Program ("Program") operated by Pharming Healthcare Inc. which provides me certain clinical and nursing support services related to my use of the biologic RUCONEST, manufactured by Pharming Healthcare Inc., for treatment of my HAE condition. The Program is administered by the Lash Group. This authorization will allow Pharming Healthcare Inc., the Lash Group, my pharmacy, healthcare providers, and health plan to use and disclose certain health information about me to facilitate my treatment with RUCONEST and to improve the Program for the benefit of future patients with HAE. I hereby authorize the use or disclosure of my protected health information (PHI) defined below for the purposes described in Section 5 below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive and use my PHI is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations and there is a potential for my PHI to be subject to redisclosure by the recipients.
2. Persons/organizations who may disclose my PHI:
  - Pharming Healthcare Inc. and its authorized representatives ("Pharming")
  - Lash Group
  - My pharmacy(ies) providing the RUCONEST
  - My healthcare provider(s), including physicians and home care nurse educators
  - My health plan(s) providing medical care and prescription coverage
3. Persons/organizations who may receive and use my PHI:
  - Pharming Healthcare Inc. and its authorized representatives
  - Lash Group
  - My pharmacy(ies) that provide RUCONEST
  - My healthcare provider(s), including physicians and home care nurse educators
  - My health plan(s) providing medical care and prescription coverage
4. My PHI consists of the following information about me that may be used or disclosed:
  - Information I provided on the RUCONEST Enrollment Form
  - My healthcare records related to my treatment and HAE condition
  - My health insurance information regarding my coverage, copay, deductibles, and benefit options
  - My prescription information, such as status, fulfillment, and/or shipment of my medication
  - My hospital records for any hospitalization and information related to my transition of care
5. My PHI may be used and disclosed for the following purposes:
  - Administration of the Program
  - Internal data collection and reporting
  - Tracking items such as health/prescription plan coverage, patient cost, shipments of the RUCONEST, health plan coverage trends, use of the Program offerings
  - Nursing services for the purposes of improving the quality of the Program
  - Assessing ongoing and future needs of patients who are prescribed RUCONEST
  - Analyzing the quality, efficacy, and safety of RUCONEST
6. I understand that the specialty pharmacies that dispense my medication may be paid for sharing my PHI with the Program and Pharming so that the recipients may use it for the purposes specified in this authorization.
7. My authorization will remain in effect for two (2) years from the date of my signature unless I revoke it before then. I understand that I may be requested to provide my written authorization on an annual basis by the Program to support continued access to my PHI. I understand that after I have signed this authorization, I may revoke it at any time by sending a written notice to the RUCONEST SOLUTIONS Program at PO Box 221974, Charlotte, NC 28222-1974. The revocation goes into effect once it has been received by the RUCONEST SOLUTIONS Program, and my healthcare providers and health plan, but the revocation will not affect any of my PHI already disclosed in reliance on this authorization.
8. I understand that I can refuse to sign this authorization and it will not affect the start, continuation, or quality of my treatment from my healthcare provider, payment for my treatment or my eligibility for or enrollment in health coverage.  
  
However, I understand that if I choose not to sign this authorization or revoke it after signing this form, the Program will not be able to provide me with the support described above, after the date of revocation.
9. I understand that I am entitled to a copy of this Authorization after signing below.

**Patient Sign** Signature of patient or patient's representative ..... Date .....

**Print Name** Printed name of patient or patient's representative ..... Relationship to patient .....