BERINERT® EXPERT NETWORK (B.E.N.®)

INSURANCE VERIFICATION REQUEST–PRESCRIPTION REFERRAL FORM

FAX: 1-866-415-2162 TOLL FREE: 1-877-BEN-4HAE (1-877-236-4423)

Please complete the form. Submit via fax. Upon completion, benefit information form will be faxed to you. Information may be shared with specialty pharmacies or other providers that may be able to assist you.

1 SECTION ONE: Patient Information

Patient Name ______________ DOB ____ / ____ / ____ SSN (last 4 digits only) __ __ __ __ Sex: ☐ M ☐ F Current Therapy ______________

Street Address ______________ City ______________ State ______ Zip ______________

Home Phone ______________ Mobile Phone ______________ Work Phone ______________ Ext ________

Email ______________ Caregiver Name ______________

Relationship to Patient ______________ Caregiver Phone ______________

2 SECTION TWO: Patient Insurance Information—Please attach copies of both sides of patient's insurance card(s)

Check if patient does not have insurance ☐

Primary Insurance Company Name ______________

Insurance Phone ______________ Fax ______________

Group # ______________ Policy # ______________

Policy Holder Name ______________

Policy Holder Relationship to Patient ______________

Policy Holder Date of Birth ______________

Secondary Insurance Company Name ______________

Insurance Phone ______________ Fax ______________

Group # ______________ Policy # ______________

Policy Holder Name ______________

Policy Holder Relationship to Patient ______________

Policy Holder Date of Birth ______________

Pharmacy Plan Name ______________ Phone ______________ Group # ______________

Policy # ______________ Rx BIN # ______________ Rx PCN # ______________

3 SECTION THREE: Patient Authorization (Optional)

I hereby authorize my healthcare providers, including pharmacies, to release and disclose to B.E.N.® and its contractors, including AccessMED, the program administrator (collectively "B.E.N.®") my prescription, and health insurance information. B.E.N.® may use and disclose this information to help me obtain and pay for Berinert, and inform me about B.E.N.® programs. This authorization will expire one year after I stop taking Berinert. I understand that: (a) I can revoke this authorization at any time by writing to Berinert Expert Network (B.E.N.®), 6900 College Blvd., Suite 1000, Overland Park, KS 66211, but that any revocation will not apply to information released unless a releasing party receives the revocation; (b) once my information is disclosed under this authorization it may be further disclosed and no longer protected by federal privacy law; and (c) that my treatment, payment, eligibility for or enrollment in benefits may not be conditioned on my signing this authorization, but that if I do not sign it, I will not be eligible for reimbursement help from, or participation in, certain B.E.N.® programs. I understand that I am entitled to a copy of this authorization once signed by me.

☐ I authorize AccessMED to provide my contact information to the U.S. Hereditary Angioedema Association.

PATIENT SIGNATURE (Optional): ______________ **DATE:** ______________

4 SECTION FOUR: Prescribing Physician Information

Physician Name ______________ Specialty ______________

Facility Name ______________ Facility or Physician Tax ID # ______________

State License # ______________ DEA # ______________ NPI # ______________

Facility Street Address ______________ City ______________ State ______ Zip ______________

Office Contact ______________ Phone ______________ Fax ______________ Email ______________

After Hours Phone ______________ List any hospitals with which you are affiliated ______________

5 SECTION FIVE: Prescription Information

Rx: Berinert (C1 Esterase Inhibitor [Human]) **NDC:** 63833-825-02 (Berinert C1 Esterase Inhibitor [Human]) 500 Units **Diagnosis:** (ICD-9) ________ **Patient Weight:** ______Kg

Dose: (20 U/Kg) **Dispense:** ☐ 2 Doses ☐ 3 Doses ☐ Other______________ **Number Days Supply:** ______________ **Refills:** __________

Prescription Type: ☐ New ☐ Continuing Therapy ☐ Restart ☐ **Drug Allergies:** ______________ ☐ NKA

Administration: ☐ Train for Self-Administration ☐ Other **Special Instructions:** ______________

☐ Pharmacy to provide anaphylactic kit per provider protocol **Must Select:** ☐ Dispense as Written ☐ Substitution Permitted

Select Specialty Pharmacy Provider: In this section, you can choose to have the Berinert Expert Network (B.E.N.®) perform a benefit investigation for your patient, OR you can request that this form be sent to a preferred Specialty Pharmacy Provider to perform the benefit investigation and provide service to the patient.

☐ **Patient's In-network Provider:** The Berinert Expert Network (B.E.N.®) will contact the patient's insurer to confirm coverage options for Berinert, including in-network specialty pharmacies. If a preferred pharmacy has also been indicated below, the Berinert Expert Network (B.E.N.®) will specifically inquire if this pharmacy is able to provide in-network benefits.

☐ **Send to Preferred Specialty Pharmacy:** ☐ Accredo ☐ Biofusion ☐ BioRx ☐ BioScrip ☐ Caremark ☐ Coram ☐ Crescent ☐ CuraScript ☐ Walgreens/OptionCare

Physician Authorization (Required)

I certify that Berinert is medically necessary for this patient. I will be supervising the patient's treatment accordingly. Non-approval of Berinert may result in further deterioration of patient's health and/or hospitalization. By signing below, I certify that I have received the necessary written authorization to release the medical and/or other patient information referenced on this form relating to the above-referenced patient to CSL Behring's contracted agent or contractors for the purpose of seeking reimbursement through the Berinert Expert Network (B.E.N.®), verifying insurance coverage and/or the evaluation of the patient's eligibility for alternate sources of funding, and product fulfillment via specialty pharmacies.

PHYSICIAN'S SIGNATURE (required to process prescription)______________ DATE ______________

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