Icatibant Referral Form

Phone: (814) 844-1943
Fax: (814) 844-1944
Email: connect@realospecialtycare.com

Patient Information

Name: _____ DOB: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Sex: ☐ Male ☐ Female

Height: _____ Weight: _____ ☐ lbs ☐ kgs

Allergies: ☐ NKDA ☐ _____

Required Documentation Insurance Card | History & Physical | Patient Demographics | Recent Labs | Medication List

Primary Diagnosis

☐ ICD-10 Code: _____

Order Information

Primary Medication Order

☐ **Icatibant** | 30mg/3ml injected subq in the abdominal area

- If response is inadequate or symptoms recur, additional injections of 30 mg may be administered at intervals of at least 6 hours.
- Do not administer more than 3 injections in 24 hours.

Quantity: _____ Refill: _____

Days Supply: _____

Provider Information

Name: _____ Office Contact: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Email: _____ NPI: _____

Prescriber Signature: I authorize Realo Specialty Care Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

_____ _____

Provider Signature Date