



Synagis Team  
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# RSV / Synagis Enrollment / Prescription Form

Specialty Pharmacy Enrollment Form

Please detach before submitting to a pharmacy – tear here.

## PATIENT INFORMATION (Section must be completed to process prescription)

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Gender:  M  F  
 Parent/Guardian \_\_\_\_\_ Last Four of SS# \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Address \_\_\_\_\_ Alternate Phone \_\_\_\_\_  
 City \_\_\_\_\_ State & ZIP \_\_\_\_\_ Language Preference:  English  Spanish  Other \_\_\_\_\_

## INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides)

Prior Authorization Reference number \_\_\_\_\_

## PHYSICIAN INFORMATION AND PRESCRIPTION FOR SYNAGIS

Referring Physician \_\_\_\_\_ NPI # \_\_\_\_\_  
 Practice Name \_\_\_\_\_ DEA # \_\_\_\_\_  
 Address \_\_\_\_\_ Phone # \_\_\_\_\_  
 Medicaid Prescriber # \_\_\_\_\_ Office Contact \_\_\_\_\_ Fax # \_\_\_\_\_

NEXT injection OR FIRST injection due. Date \_\_\_\_\_ Has first dose been given?  Yes  No If Yes, When? \_\_\_\_\_ Where? \_\_\_\_\_

Subsequent injections will be administered in:  Hospital  MD Office  Patient's Home  Other \_\_\_\_\_

Check here to have us coordinate nursing for in-home injections. (service available in select regions)

Preferred home health agency, if any \_\_\_\_\_ Already in the home? \_\_\_\_\_

## PRESCRIPTION INFORMATION

Medication	Strength	Directions	Quantity	Total Doses Requested
<input type="checkbox"/> Rx Synagis®	50 and/or 100mg vials	Inject 15mg/kg IM one time per month	Other: QS to achieve 15mg/kg dose	
<input type="checkbox"/> Rx Epinephrine	1:1000 amp	Inject 0.01 mg/kg subcutaneously as directed for anaphylaxis	QS	

Previous injections (including doses given in hospital):  Yes  No If Yes, dates: \_\_\_\_\_

Which months are requested for the current season? (Circle) Nov. Dec. Jan. Feb. Mar. Other (specify) \_\_\_\_\_

Specialty pharmacy to coordinate injection training/home health nurse visit as necessary  Yes  No

Allergies:  Yes  No If Yes, please list: \_\_\_\_\_

Other medical history: \_\_\_\_\_

Has the child been previously approved for Synagis by another insurance carrier for the current season?  Yes  No

(Please attach approval from previous insurance carrier and clinical notes for doses already given)

\*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to:  Patient  Office  Other \_\_\_\_\_ Date \_\_\_\_\_ Needs by Date \_\_\_\_\_

Product Substitution permitted  Dispense as Written

Prescriber's Signature \_\_\_\_\_ Date: \_\_\_\_\_ Supervising Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Electronic or digital signatures not accepted.

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.

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## CLINICAL INFORMATION

Patient's Gestational Age (Required): \_\_\_\_\_ Weeks \_\_\_\_\_ Days

Patient is a multiple birth:  No  Yes

• Current weight in: \_\_\_\_\_ kilograms (kg) \_\_\_\_\_ pounds (lbs) Date recorded: \_\_\_\_\_

**Chronic lung disease (CLD):**  No  Yes ICD-10 Code: \_\_\_\_\_ (attach medical history)

• Require more than 21% oxygen at least 28 days after birth:  No  Yes

• Therapy received within 6 months start of RSV season (check all that apply):

Supplemental oxygen: Last date \_\_\_\_\_

Chronic systemic corticosteroid therapy: Last date \_\_\_\_\_ Drug name \_\_\_\_\_

Diuretics therapy: Last date \_\_\_\_\_ Drug name \_\_\_\_\_

**Congenital heart disease (CHD):**  No  Yes ICD-10 Code: \_\_\_\_\_ (attach medical history)

• Acyanotic heart disease:  No  Yes

• Cyanotic heart disease:  No  Yes

• Moderate to severe pulmonary hypertension:  No  Yes

• Requires cardiac surgical procedure:  No  Yes

• In consultation with pediatric cardiologist during first year of life:  No  Yes

• List cardiac medications:

\_\_\_\_\_ Last date received: \_\_\_\_\_

\_\_\_\_\_ Last date received: \_\_\_\_\_

\_\_\_\_\_ Last date received: \_\_\_\_\_

**Compromised handling of respiratory secretions:**  No  Yes ICD-10 Code: \_\_\_\_\_ (attach medical history)

**Congenital abnormality of the lower airway:**  No  Yes ICD-10 Code: \_\_\_\_\_ (attach medical history)

**Neuromuscular condition:**  No  Yes ICD-10 Code: \_\_\_\_\_ (attach medical history)

**Receiving chemotherapy:**  No  Yes ICD-10 Code: \_\_\_\_\_ (attach medical history)

**Cystic Fibrosis:**  No  Yes ICD-10 Code: \_\_\_\_\_ (attach medical history)

• Prior hospitalization for pulmonary exacerbation in first year of life:  No  Yes (attach medical history)

• Abnormal chest radiography or chest computer tomography that persists when stable:  No  Yes

## MEDICAL INFORMATION

ICD-10 Code: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

ICD-10 Code: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

List Meds and Dates \_\_\_\_\_ Ventilator and Dates \_\_\_\_\_