



SYNAGIS® REORDER FORM

To order now for next dose based on an estimated weight at time of injection, please fill out the information below and fax to **1-866-926-0463**.

| PATIENT INFORMATION | | | |
|---|--|-------------------------|--|
| Patient's name: | | | |
| Insurance ID #: | | Date of birth: | |
| Address: | | | Apartment #: |
| City: | | State: | ZIP: |
| Phone Number: | | Alternate Phone: | Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female |
| PROVIDER AND SHIPPING INFORMATION | | | |
| Provider's name: | | Physician ID (NPI/DEA): | |
| Address: | | City: | State: ZIP: |
| Suite number: | | Building number: | |
| Phone number: | | Fax number: | |
| Contact at the MD office: | | | |
| Office hours: | | Alternative phone: | Extension: |
| DELIVERY REQUEST | | | |
| Next Synagis delivery date _____ (Tuesday to Friday only) | | | |
| Pharmacist to dose next injection based on the following estimated weight: | | | |
| 1. Next injection date for Synagis _____ | | | |
| 2. Estimated patient's weight for next visit _____ kg | | | |
| Signature _____ Date _____ | | | |

Please fax to **1-866-926-0463**. For more information call **1-888-293-9309**. Select **Option 1** for Synagis.

FOR INTERNAL USE ONLY.

Image Indexing Team: Reference category = RSV; Referral Source = Office Based Deliveries

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