Synagis Team
Phone: 888-293-9309 option 1
Fax: 866-391-1890

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
☐ Rx Synagis®	50 and/or 100mg vials	Inject 15mg/kg IM one time per month	Other: QS to achieve15mg/kg dose	
☐ 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. This form is not a valid prescription in Arizona.

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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 ____