



Fax: 866-391-1890
Phone: 888-293-9309

RSV/Synagis Enrollment/Prescription Form

Please complete this form for members needing a Synagis prescription and fax it to **866-391-1890**. We will notify you and your patient of prescription coverage. This form helps determine if the patient's condition meets drug policy guidelines, so please fill it out completely. Any missing information may cause a delay in the coverage decision. If you have questions or need to request a refill, please call **888-293-9309**.

For all REFILL requests, please call 888-293-9309

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)

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	

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

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.

Product Substitution permitted Dispense as Written

Prescriber's Signature _____ Date _____ Supervising physician _____ Date _____

MEDICAL INFORMATION

ICD-10 Code: _____ Diagnosis: _____

ICD-10 Code: _____ Diagnosis: _____

List Meds and Dates _____ Ventilator and Dates _____

CLINICAL INFORMATION

Patient's Gestational Age (Required): _____ Weeks _____ Days

Patient is a multiple birth: Yes No

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

Yes No Request/Will Synagis be administered during RSV season as defined by Centers for Disease and Prevention (CDC) surveillance reports or state or local health departments to confirm the start of the respiratory syncytial virus (RSV) "season"?

Yes No Will the monthly dose of Synagis exceed 15 mg/kg per dose?

Yes No Congenital abnormalities of the airway or neuromuscular disease/ Immunocompromised children and < 24 months of age

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

Yes No Did the preterm infant develop chronic lung disease (CLD) of prematurity defined as gestational age < 32 weeks, 0 days and a requirement for >21% oxygen for at least the first 28 days after birth?

Yes No Is the infant born at < 32 weeks, 0 days gestation who are \geq 12 to < 24 months of age and required at least 28 days of oxygen after birth and who continue to require supplemental oxygen, diuretics, or chronic systemic corticosteroid therapy within 6 months of the start of the second RSV "season"?

Yes No Did the preterm infant develop chronic lung disease (CLD) of prematurity defined as gestational age < 32 weeks, 0 days and a requirement for >21% oxygen for at least the first 28 days after birth?

Yes No Is the infant born at < 32 weeks, 0 days gestation who are \geq 12 to < 24 months of age and required at least 28 days of oxygen after birth and who continue to require supplemental oxygen, diuretics, or chronic systemic corticosteroid therapy within 6 months of the start of the second RSV "season"?

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

Yes No Acyanotic heart disease

Which of the following does the child/infant have?

A. Acyanotic heart disease and receiving medication to control congestive heart failure and will require cardiac surgical procedures

B. Moderate to severe pulmonary hypertension

C. Cyanotic heart defects

D. Other _____

Yes No Was decision for Synagis prophylaxis in infant with cyanotic heart defects in the first year of life made by or in consultation with a pediatric cardiologist?

Yes No Did the child undergo cardiac transplantation during the RSV "season"?

Yes No Congenital abnormalities of the airway or neuromuscular disease: A. Age 0 to < 12 months B. Other age

Yes No Does the infant/child have impaired ability to clear secretions from the lower airway because of ineffective cough?

Yes No Immunocompromised and < 24 months of age: Is the Child receiving cancer chemotherapy or is severely immunocompromised?

• List cardiac medications:

_____ Last date received: _____

_____ Last date received: _____

_____ Last date received: _____

Cystic Fibrosis: Yes No ICD-10 Code: _____ (attach medical history)

Yes No Age 0 to <12 months: Does the infant/child have clinical evidence of Chronic lung disease (CLD) and/or nutritional compromise in the first year of life? Note: Failure to thrive is defined as weight for length less than the 10th percentile on a pediatric growth chart.

Yes No age > 12 to 24 months: For second year treatment, does infant/child have manifestations of severe lung disease including one of the following: A. Previous hospitalization for pulmonary exacerbation in the first year of life. B. Abnormalities on chest radiography or chest computed tomography that persists when stable. C. Weight for length less than the 10th percentile on a pediatric growth chart.

Prematurity:

Yes No Is the infant born before 29 weeks, days gestation and is < 12 months of age at the start of RSV season?