Please fax all pages of completed form to your drug therapy team at 808.650.6487.

To reach your team, call toll-free 808.650.6488.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form

Synagis®

accredo®
677 Ala Moana Blvd., Suite 404,
Honolulu, HI 96813-5412

Four simple steps to submit your referral.

1 Patient Information

Please provide copies of front and back of all medical and prescription insurance cards.

☐ New patient ☐ Current patient

Patient's first name _____ Last name _____ Middle initial _____

Preferred patient first name _____ Preferred patient last name _____

Sex at birth: ☐ Male ☐ Female Gender identity _____ Pronouns _____ Last 4 digits of SSN _____

Date of birth _____ Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ Email address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ Email address _____

☐ OK to leave message with alternate caregiver/contact

Patient's primary language: ☐ English ☐ Other If other, please specify _____

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____

Office/clinic/institution name _____

Prescriber's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Office phone _____ Fax _____ NPI # _____ License # _____

Office contact and title _____ Office contact email _____

Office street address _____ Suite # _____

City _____ State _____ Zip _____

Deliver product to: ☐ Prescriber's office ☐ Patient's home

3 Clinical Information

Primary ICD-10 code (REQUIRED): _____ Secondary diagnosis (if applicable) _____

Patient's Gestational Age (GA) _____ ☐ P07.21 Less than 23 completed weeks

☐ P07.22 23 completed weeks ☐ P07.23 24 completed weeks ☐ P07.24 25 completed weeks ☐ P07.25 26 completed weeks

☐ P07.26 27 completed weeks ☐ P07.31 28 completed weeks Chronological Age at RSV season onset _____

[DOB required under Patient Information] Birth Weight _____ ☐ kg ☐ lbs Current Weight _____ ☐ kg ☐ lbs

Date Weight recorded _____ ☐ NKDA ☐ Known drug allergies Concurrent meds _____

Did patient receive Synagis last year? ☐ Yes Date(s) _____ ☐ No

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

3 Clinical Information (continued)

Medical criteria for RSV Prophylaxis (please select all that apply):

☐ Prematurity Including GA ≤ 28 weeks and ≤ 12 months old at RSV season onset

☐ Hemodynamically significant congenital heart disease (CHD)
Including but not limited to: moderate to severe pulmonary hypertension, heart failure, cyanotic CHD (Q20–28, P29.3)

Cardiac Surgery (planned or recently completed) _____

Medications for CHD _____ Last date received _____

☐ Severe neuromuscular disease ☐ Congenital abnormality of airway (Q30–34)
Including but not limited to impaired cough reflex, persistent reflux, tracheostomy, pulmonary malformations, etc.

☐ Chronic Pulmonary Disease requiring medical therapy (check all that apply and provide last date received):
Including but not limited to pneumonia, respiratory failure, apnea, aspiration, etc. (P22.1, P22.8, P22.9, P23–28, P84)

☐ Oxygen _____ ☐ Corticosteroids _____ ☐ Bronchodilator _____ ☐ Diuretics _____

☐ Other _____

☐ Severe immunocompromise during the RSV season (specify condition/medications) _____
Including but not limited to cardiac or other tissue transplant, chemotherapy, primary immune disorder, etc.

☐ Other medical history/medications _____

Admission history: (Please attach most recent NICU/hospital Discharge Summary, if applicable)

Date of NICU/hospital discharge (if applicable) _____

Was Synagis given while in NICU/hospital? ☐ Yes Date(s) _____ ☐ No

4 Prescribing Information

Medication	Dose	Directions	Quantity/Refills
☐ Synagis® (palivizumab)	50mg and/or 100mg vial(s)	Inject 15mg/kg IM one time per month (every 28–30 days) *Pharmacy to provide appropriate amount/dose of 50mg and/or 100mg vials based on weight.	Dispense: ☐ 1-month supply *1 month default if no days supply specified **** Quantity sufficient for 1 month based on patient's recent weight Refills: ☐ 4 refills ☐ Other _____
☐ Epinephrine	1:1000 amp	Inject 0.01mg/kg intramuscular as directed	Dispense: Quantity of 1 Refills _____

Supplies: (Supplies will not be sent with shipment unless indicated.)
☐ Administration supplies consisting of: • Alcohol prep pads • 3mL 25G x 5/8" safety glide syringes • 25G 1" safety glide needles • Curity flexible bandages • 1mL 25G x 5/8" safety glide syringe
Supplies for epinephrine: (if prescribed) • 19G x 1 1/2" 5M filter-needle • 1mL 27G x 1/2" TB syringe with needle
Send quantity sufficient for medication days supply. ☐ No supplies

Expected date of first/next injection _____ Deliver product to: ☐ Office ☐ Patient's home ☐ Clinic

Clinic location _____ Home health agency to administer?: ☐ No ☐ Yes

Agency name & contact _____

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.
Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE

_____ _____ _____ _____

Date **Dispense as written** **Date** **Substitution allowed**

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

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