Prescription & Enrollment Form

Synagis®

accredo®

Four simple steps to submit your referral.

1 PATIENT INFORMATION

❑ New patient ❑ Current

Patient first name ______
Last name ______ Middle initial ______
Date of birth ______ ❑ Male ❑ Female Last 4 digits of SSN ______
Street address ______ Apt # ______
City ______ State ______ Zip ______
Parent/guardian (if applicable) ______
Home phone ______ Work phone ______ Cell phone ______
Evening phone ______ E-mail address ______
Patient's primary language: ❑ English ❑ Other If other, please specify ______

Please attach copies of front and back of patient's insurance cards or complete information below.

Insurance company ______ Phone ______
Insured's name ______
Insured's employer ______ Relationship to patient ______
Identification # ______ Policy/group # ______
Prescription card: ❑ Yes ❑ No If yes, carrier ______
Policy # ______ Group # ______ Is patient eligible for Medicare? ❑ Yes ❑ No
Does patient have a secondary insurance? ❑ Yes ❑ No
Was this patient a multiple birth? ❑ Yes ❑ No

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date ______ Time ______ Date medication needed ______
Prescriber's first name ______ Last name ______
Prescriber's title ______
If NP or PA, under direction of Dr. ______
Office contact and title ______
Office contact email ______
Office/clinic/institution name ______
Clinic/hospital affiliation ______
Street address ______ Suite # ______
City ______ State ______ Zip ______
Phone ______ Fax ______
NPI # ______ License # ______
Deliver product to: ❑ Office ❑ Patient's home ❑ Clinic
Clinic location ______

3 CLINICAL INFORMATION

Primary diagnosis (ICD-10 code) ______
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

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: mod. 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, pulm. 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	Strength / Formulation	Directions	Quantity
Synagis® (palivizumab)	50 mg and/or 100 mg vial(s)	Inject 15 mg/kg IM one time per month (every 28–30 days) *Pharmacy to provide appropriate amount/dose of 50 mg and/or 100 mg vials based on weight provided by prescriber. Pharmacy please deliver a max of ______ doses or monthly through ______ date. ***If no end date provided, pharmacy will discontinue automatically at maximum of 5 doses or insurance authorization end date, whichever comes first.***	Dispense: ❑ 1-month supply *1 month default if no DS specified **Quantity sufficient for 1 month based on patient's recent weight Refills: ❑ 4 refills ❑ Other refills ______
❑ Epinephrine	1:1000 amp	Inject 0.01 mg/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
- Curity flexible bandages
- 3 mL 25G x 5/8" safety glide syringes
- 1 mL 25G x 5/8" safety glide syringe
- 25G 1" safety glide needles

Supplies for epinephrine: (if prescribed)
- 19G x 1 1/2" 5M filter-needle
- 1 mL 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, physician accepts on behalf of patient for administration in office. **By signing below, I certify that the above therapy is medically necessary.**
Prescriber's printed name ______ Date ______
Prescriber's signature (sign below) (Physician attests this is his/her legal signature. **NO STAMPS**)

PHYSICIAN SIGNATURE REQUIRED

______ ______ ______ ______
Date Substitution allowed Date Dispense as written

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.

Please fax completed form to your drug therapy team at 877.369.3447. To reach your team, call toll-free 877.482.5927.

You can now track shipments for all your Accredo patients. Go to https://prescribers.accredo.com and click "Help" to register.

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