NC Synagis® Statement of Medical Necessity and Assignment of Benefits Program Enrollment Form

Referral Source ID _____ (Accredo Health Group, Inc. use ONLY)

Prescriber's Name: _____ **Practice Name:** _____

Address: _____ **City**: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____ **Office Contact:** _____

License # _____ **DEA #** _____ **NPI #** _____

Patient Name: _____ **DOB** _____ Sex: ❑ Male ❑ Female

Patient's SS # (last 4 digits) _____ Parent's/Guardian's Name _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Insured Name: _____ Relationship to Patient: _____

Insured's SS# (last 4 digits) _____ Insured's Employer (if known) _____

Insurance Company Name: _____ Insurance Phone: _____

Group Number _____ ID Number _____ Carrier Number _____

Prescription Card: ❑ Yes ❑ No If yes, Carrier _____ Phone _____

Group Number _____ ID Number _____

Secondary Insurance _____ ID Number _____

Insurance Phone _____ **WAS THIS PATIENT A MULTIPLE BIRTH? ❑ Yes ❑ No**

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

Patient Actual Gestational Age _____ Please check appropriate box/boxes below:

❑ **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

Additional Risk Factors: *Please check all that apply*

❑ School Age Siblings Other: _____

❑ Attends Day Care _____

❑ Neuromuscular Disease

❑ Severe Immunocompromise related to: _____ (specify)

❑ Congenital abnormalities of the airways

Current Weight: _____ lb/kg Date: _____ Birth Weight: _____ lb/kg

Is there a history of medical therapies within the last 6 months? ❑ Yes ❑ No If yes, please describe _____

_____

Other Medical History _____

_____

Are there any special precautions needed? ❑ Yes ❑ No If yes, please describe _____

Anticipated date of first outpatient injection _____

Rx: Synagis® (palivizumab)

Sig: ❑ Inject 15 mg/kg IM monthly

❑ NKDA ❑ Known Drug Allergies _____

Dispense Quantity: ❑ 1 month ❑ 3 months **Refills:** _____

Prescriber Full Signature (please sign one line below –no stamps): Date: _____

Prescriber certifies this is his or her full and usual signature.

_____ _____

Dispense as written Substitution allowed

I authorize HUB to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan.

	Fax Number:	Phone Number:	Date Faxed:
Accredo	877.369.3447	877.482.5927	

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