2015-2016 Synagis® Seasonal Respiratory Syncytial Virus Enrollment Form

MedStar Family Choice

Fax Referral To: 877-552-2907
Phone: 888-345-1678
Email Referral To: customerservicefax@caremark.com

6 Simple steps to submitting a referral

1 PATIENT INFORMATION

(*Complete the following or include demographic sheet*)

Patient Name:_____
Address: _____
City, State, Zip:_____
Primary Phone:_____ ☐Home ☐Cell ☐Work
Alternate Phone:_____ ☐Home ☐Cell ☐Work
DOB:_____ Gender: ☐ Male ☐ Female
E-mail: _____
Last Four of SS #:_____Primary Language:_____
Parent/Guardian Name: _____

2 PRESCRIBER INFORMATION

Prescriber's Name:_____
State License #:_____ NPI #:_____
DEA #:_____
Group or Hospital:_____
Address:_____
City, State, Zip:_____
Phone: _____ Fax: _____
Contact Person:_____ Phone:_____

3 INSURANCE INFORMATION

Please fax a copy of prescription and insurance cards with this form, if available (front and back).

Prescription Card: Name of Insurer: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____

Prescription Insurance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____

Secondary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date:_____ Expected date of first injection: _____ Ship to: ☐ Prescriber Office ☐ Patient Home ☐ Other: _____
☐ Yes, CVS Caremark is to coordinate home health nurse visit for injection ☐ No coordination If yes, agency of choice: _____

Diagnosis (ICD-9 or ICD-10)

☐ < 24 wks of gestation (765.21) ☐ 24 wks of gestation (765.22) ☐ 25-26 wks of gestation (765.23) ☐ 27-28 wks of gestation (765.24)
☐ 29-30 wks of gestation (765.25) ☐ 31-32 wks of gestation (765.26) ☐ 33-34 wks of gestation (765.27) ☐ 35-36 wks of gestation (765.28)
☐ 37 wks + of gestation (765. 29) ☐ Congenital Heart Disease (Specify ICD-9): _____ ☐ Other: _____
☐ Chronic Respiratory Disease arising in the perinatal period (CLD) (770.7) ☐ Congenital Abnormality of Respiratory System (748.3-748.4)

Patient's gestational age (Required) weeks days | Current weight: g/kg/lbs | Date recorded: / /

Multiple births: ☐ No ☐ Yes Enter names of Synagis candidates (submit separate enrollment forms):
NICU history: ☐ No ☐ Yes If yes, NICU name & include NICU summary:
Allergies: Medical conditions not listed below:

Clinical Conditions	2014 AAP Committee on Infectious Disease and Bronchiolitis Guidelines
Chronic Lung Disease (CLD)	*CLD of prematurity defined as gestational age ≤ 31 weeks, 6 days, AND requirement for 21% oxygen for at least the first 28 days after birth ☐ < 12 months of age w CLD * ☐ 12-24 months of age w CLD * AND continues to require medical support* during the 6-month period before second RSV season AND ☐ Supplemental oxygen (dates) _____ ☐ Diuretic therapy (drugs/dates) _____ ☐ Chronic corticosteroids (drugs/date) _____ ☐ Bronchodilators (drugs/dates) _____
Congenital Heart Disease (CHD)	☐ < 12 months of age at start of season with hemodynamically significant CHD such as: ☐ Acyanotic heart disease and receiving medication to control congestive heart failure and surgery to correct (Meds/dates) _____ (Surgery date) _____ ☐ Moderate to severe pulmonary hypertension ☐ Other: describe _____ ☐ < 24 months of age undergoing cardiac transplantation during the RSV season (date)
Airway/Neuromuscular Conditions	☐ < 12 months of age at start of season and compromised handling of secretions AND due to: ☐ Significant abnormality of the airway (attach clinical notes) ☐ Neuromuscular condition (attach clinical notes)
Prematurity	☐ ≤ GA 28 wks, 6 days AND < 12 months at start of season
Other medical history or conditions	☐ Other medical history (describe)

5 PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Synagis® (palivizumab) and ancillary supplies*	☐ 50 and/or 100 mg vials	☐ Inject 15 mg/kg IM one time per month ☐ Other: _____	QS to achieve 15mg/kg dose	
☐ Epinephrine and ancillary supplies **	1:1000 amp	Inject 0.01 mg/kg subcutaneously as directed for anaphylaxis		

*This prescription also covers ancillary supplies (syringes, needles, etc.) for administration as needed. **When required for home/injection clinic administration

☐ Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

6 PHYSICIAN SIGNATURE REQUIRED

X _____
DISPENSE AS WRITTEN (Date)

X _____
PRODUCT SUBSTITUTION PERMITTED (Date)

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