

**NC Synagis® Statement of Medical Necessity and Assignment of Benefits Program Enrollment Form**  
 2009-2010 Referral Source ID \_\_\_\_\_ (Accredo Health Group, Inc. use ONLY)

<b>Prescriber's Name:</b> _____		<b>Practice Name:</b> _____	
<b>Address:</b> _____	<b>City:</b> _____	<b>State:</b> _____	<b>Zip:</b> _____
<b>Phone:</b> _____	<b>Fax:</b> _____	<b>Office Contact:</b> _____	
<b>License #</b> _____	<b>DEA #</b> _____		

<b>Patient Name:</b> _____	<b>DOB</b> _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> 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 _____	<b>ID Number</b> _____	Carrier Number _____
Prescription Card: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Carrier _____	Phone _____
Group Number _____	ID Number _____	
Secondary Insurance _____	ID Number _____	
Insurance Phone _____	<b>WAS THIS PATIENT A MULTIPLE BIRTH? YES NO</b>	

<b>Patient Actual Gestational Age</b> _____	<b>Please check appropriate box/boxes below:</b>	
<input type="checkbox"/> 765.21-765.22 ≤ 24 weeks gestation	<input type="checkbox"/> 765.24 = 27-28 weeks gestation	<input type="checkbox"/> 765.26 = 31-32 weeks gestation
<input type="checkbox"/> 765.23 = 25-26 weeks gestation	<input type="checkbox"/> 765.25 = 29-30 weeks gestation	<input type="checkbox"/> 765.27 = 33-34 weeks gestation
<input type="checkbox"/> 765.28 = 35-36 weeks gestation		
<input type="checkbox"/> 770.7 Chronic Respiratory Disease Arising in Perinatal Period (ie:Bronchopulmonary Dysplasia, Interstitial Pulmonary Fibrosis) Therapy within 6 mos of season † Supplemental oxygen † Bronchodilator † Diuretic † Corticosteroid		
<input type="checkbox"/> 747.0-745.4 Congenital Heart Disease ICD9 code- Diagnosis: _____		
<input type="checkbox"/> 770.0-770.9 Other Respiratory Conditions arising in newborn period. Please indicate ICD9 code and description: _____		
<input type="checkbox"/> Other Dx.: _____		
<b>Additional Risk Factors: (32 to 35 week GA often requires additional risk factors) Please check all that apply</b>		
<input type="checkbox"/> School Age Siblings	Other : _____	
<input type="checkbox"/> Attends Day Care	_____	
<input type="checkbox"/> Neuromuscular Disease		
<input type="checkbox"/> Exposure to Environmental Air Pollutants: _____		
<input type="checkbox"/> Congenital abnormalities of the airways	(Name Pollutant) _____	
Current Weight: _____ lb/kg	Date: _____	Birth Weight: _____ lb/kg
Is there a history of medical therapies within the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe _____		
_____ Other Medical History _____		
Are there any special precautions needed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe _____		
Anticipated date of first outpatient injection _____		

<b>Rx: Synagis® (palivizumab)</b>	
<b>Sig:</b> <input type="checkbox"/> Inject 15/mg/kg IM /monthly	
<input type="checkbox"/> NKDA	<input type="checkbox"/> Known Drug Allergies _____
<b>Dispense Quantity: QS</b>	<b>Refills:</b> _____
Prescriber Full Signature (please sign one line below –no stamps): _____	Date: _____
_____	_____
Dispense as written	Substitution allowed
Prescriber certifies this is his or her full and usual signature.	

	<b>Fax Number:</b>	<b>Phone Number:</b>	<b>Date Faxed:</b>
Accredo	1 877 369-3447	1 877 482-5927	