

NC Synagis® Statement of Medical Necessity and Assignment of Benefits Program Enrollment Form
 2007-2008 Referral Source ID _____ (Accredo Health Group, Inc. use ONLY)

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

Patient Name: _____	DOB _____	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 _____	ID Number _____	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 _____	WAS THIS PATIENT A MULTIPLE BIRTH? YES NO	

Patient Actual Gestational Age _____	Please check appropriate box/boxes below:	
<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.: _____		
Additional Risk Factors: (32 to 35 week GA often requires additional risk factors) Please check all that apply		
<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 _____		

Rx: Synagis® (palivizumab)	
Sig: <input type="checkbox"/> Inject 15/mg/kg IM /monthly	
<input type="checkbox"/> NKDA	<input type="checkbox"/> Known Drug Allergies _____
Dispense Quantity: QS	Refills: _____
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.	

	Fax Number:	Phone Number:	Date Faxed:
Accredo	1 877 369-3447	1 877 482-5927	