Prescription & Enrollment Form

Synagis®

accredo®
677 Ala Moana Blvd., Suite 404,
Honolulu, HI 96813-5412

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)	50mg and/or 100mg vial(s)	Inject 15mg/kg IM one time per month (every 28–30 days) *Pharmacy to provide appropriate amount/dose of 50mg and/or 100mg 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 0.01mg/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
- 3mL 25G x 5/8" safety glide syringes
- 1mL 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
- 1mL 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 ______
By signing below, I certify that the above therapy is medically necessary. I also authorize Accredo to initiate any de minimus authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited. **Prescriber's signature (sign below)** (Physician attests this is his/her legal signature. **NO STAMPS**) **PHYSICIAN SIGNATURE REQUIRED**

______ ______ ______ ______
Date Dispense as written Date Substitution allowed

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 808.650.6487. To reach your team, call toll-free 808.650.6488.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

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