Please fax both pages of completed form to your drug therapy team at 877.369.3447.

To reach your team, call toll-free 877.482.5927.

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

Prescription & Enrollment Form

Synagis®

accredo®

Four simple steps to submit your referral.

1 Patient Information

Please attach copies of front and back of the patient's medical and prescription insurance cards.

❑ New patient ❑ Current patient

Patient's first name _____ Last name _____ Middle initial _____

❑ Male ❑ Female Last 4 digits of SSN _____ Date of birth _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ E-mail address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ E-mail address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ E-mail address _____

❑ OK to leave message with alternate caregiver/contact Patient's primary language: ❑ English ❑ Other _____

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 address _____

Office contact and title _____

Office contact phone number _____ Office contact e-mail _____

Office/Infusion clinic name _____ Office/Infusion clinic 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 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

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

3 Clinical Information (continued)

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: moderate 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, pulmonary 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	Dose	Directions	Quantity/Refills
❑ 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 _____
❑ 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 • 3mL 25G x 5/8" safety glide syringes • 25G 1" safety glide needles • Curity flexible bandages • 1mL 25G x 5/8" safety glide syringe
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 or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

Prescriber's signature (sign below) **(Physician attests this is his/her legal signature. NO STAMPS)**

PHYSICIAN SIGNATURE REQUIRED

SIGN HERE

_____ _____ _____ _____

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.

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