

NC Synagis® Statement of Medical Necessity and Assignment of Benefits Program Enrollment Form

Referral Source ID _____ (Accredo Health Group, Inc. use ONLY)

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

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? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Primary diagnosis (ICD-10 code) _____		Secondary diagnosis (if applicable) _____	
Patient Actual Gestational Age _____ Please check appropriate box/boxes below:			
<input type="checkbox"/> P07.21 Less than 23 completed weeks			
<input type="checkbox"/> P07.22 23 completed weeks			
<input type="checkbox"/> P07.23 24 completed weeks			
<input type="checkbox"/> P07.24 25 completed weeks			
<input type="checkbox"/> P07.25 26 completed weeks			
<input type="checkbox"/> P07.26 27 completed weeks			
<input type="checkbox"/> P07.31 28 completed weeks			
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"/> Severe Immunocompromise related to: _____			
<input type="checkbox"/> Congenital abnormalities of the airways (specify) _____			
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: <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months		Refills: _____	
Prescriber Full Signature (please sign one line below –no stamps): _____		Date: _____	
Prescriber certifies this is his or her full and usual signature.			
Dispense as written		Substitution allowed	
I authorize HUB to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan. The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.			
All rights in the product names, trade names or logos of all third-party products that appear in this form, whether or not appearing with the trademark symbol, belong exclusively to their respective owners.			

	Fax Number:	Phone Number:	Date Faxed:
Accredo	877.369.3447	877.482.5927	