

ARE YOU REFERRING THIS PATIENT FROM A *NICU / HOSPITAL*?

YES NO

1

FAX COMPLETED FORM TO:



1-800-447-3694

Questions? Please call 1-800-990-9247

2

PATIENT INFORMATION

Last Name	First Name	Middle Initial
Street Address	City	
County	State	ZIP Code <input type="checkbox"/> M <input type="checkbox"/> F
Date of Birth	Social Security Number	Sex
Parent/Guardian		
Day Telephone (+Area Code)	Night Telephone (+Area Code)	

INSURANCE INFORMATION

Include copies of the patient's insurance cards and drug benefit cards (front and back) to expedite benefit clearance.

Primary Insurance	Secondary Insurance
Cardholder Name & Social Security Number (If Not Patient)	Cardholder Name & Social Security Number (If Not Patient)
Group Number	Group Number
Policy Number	Policy Number
Insurance Telephone Number (+Area Code)	Insurance Telephone Number (+Area Code)
Employer	

3

PHYSICIAN INFORMATION

Referring Physician	Hospital/Clinic	Office Contact
Address	City/State/ZIP	Telephone Number (+Area Code)
Prescriber's License Number	DEA Number	Fax Number (+Area Code)
Medicaid Provider Number	UPIN Number	
Following Physician	Practice Name	Phone Number

4

CLINICAL INFORMATION

EXPECTED DATE OF FIRST/ NEXT INJECTION: _____

Injection will be administered in: Office Patient's Home Clinic

Check here if Pharmacare is to coordinate home nursing

If home nursing is already established, please provide agency name and phone number below.

Agency _____ Phone _____

PRIMARY DIAGNOSIS:

Patient's Gestational Age (GA) _____ Birth Weight _____ kg (lb)

Current Weight _____ kg (lb) Date Recorded _____

- Congenital Heart Disease (745.0-747.9) 29-30 weeks GA (765.25)
- Chronic Respiratory Disease Arising in the Perinatal Period (CLD) (770.7) 31-32 weeks GA (765.26)
- ≤24 weeks GA (765.21-765.22) 33-34 weeks GA (765.27)
- 25-26 weeks GA (765.23) 35-36 weeks GA (765.28)
- 27-28 weeks GA (765.24) 37 or more weeks GA (765.29)
- Other Respiratory Conditions of Fetus and Newborn (770.0-770.9) Congenital Anomalies of Respiratory System (748)
- Other _____ Secondary diagnosis (if applicable) _____

MEDICAL CRITERIA:

- Diagnosis of chronic pulmonary disease (CLD/BPD) and less than 24 months of age? Yes No
- Diagnosis of hemodynamically significant congenital heart disease and less than 24 months of age? Yes No
- Prematurity: Gestational age of ≤28 weeks and <12 months of age at the start of RSV season
 Gestational age of 29-32 weeks and <6 months of age at the start of RSV season
 Gestational age of 32-35 weeks and <6 months at the start of RSV season

Clinically has the following risk factors (Check all that apply):

- School-age siblings Birth weight less than 2500 g
- Exposure to environmental air pollutants Crowded living conditions
- Day care Multiple birth
- Severe neuromuscular disease Family history of asthma
- Congenital abnormality of airway

Other medical history: _____

NICU HISTORY:

Did the patient spend time in the NICU? Yes No If yes, please attach the NICU Discharge Summary

Was RSV prophylaxis recommended by the NICU/HOSPITAL physicians for this patient? Yes No

Was there a NICU/HOSPITAL dose administered? Yes Date(s): _____ No

Rx

Synagis® (palivizumab) 50mg and/or 100mg vials

Sig: Inject 15 mg/kg IM one time per month

Dispense Quantity: QS for weight based dosing

Refills through 6-1-07

Syringes 1ml 25G 5/8"

Epinephrine 1:1000 amp (if required for home administration). Sig: Inject 0.01 mg/kg as directed

Known Allergies: _____

Other _____

Sig: _____

Prescriber's Signature _____