

**Patient Information**

Name (First, Last) \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_ Birth Wt. \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Primary Guardian \_\_\_\_\_ Secondary Guardian \_\_\_\_\_  
 Primary Phone # \_\_\_\_\_ Secondary Phone # \_\_\_\_\_  
 Patient one of multiple births?  Yes  No / If yes, is sibling(s) referral being submitted simultaneously?  Yes  No  
 Sibling name(s) \_\_\_\_\_

**Insurance Information**

No Insurance  Copy of Front and Back of Medical and/or Pharmacy Card Included

	Primary Insurance	Secondary Insurance	Pharmacy Benefit
Insurance Name			
Cardholder Name (if not patient)/DOB			
Group Number			
Policy Number			
Insurance Phone #			
BIN #	N/A	N/A	

Independent Practice Association (IPA) / Accountable Care Organization (ACO) (if applicable): \_\_\_\_\_

**Prescriber Information**

**Treating**

**Referring**

Provider Name		
Site Name		
Site Address (Street/City/State/ZIP)		
Telephone # / Fax #	/	
Office Contact		
NPI #		N/A
License # / Tax ID #	/	N/A
Medicaid Provider # / DEA #	/	N/A

**Diagnosis**

Patient's gestational age (GA) \_\_\_\_\_ Current weight \_\_\_\_\_ kg \_\_\_\_\_ lbs-oz Date current weight recorded \_\_\_\_\_

PRIMARY: ICD-9 \_\_\_\_\_ or ICD-10 \_\_\_\_\_

SECONDARY: ICD-9 \_\_\_\_\_ or ICD-10 \_\_\_\_\_

See fax cover sheet for common ICD-9 codes used for Synagis

CLINICAL INFORMATION:  Medical records included

1.  CLDP/BPD: Diagnosis of chronic lung disease of prematurity/bronchopulmonary dysplasia and ≤24 months of age (Specific Diagnosis Code \_\_\_\_\_)

Is patient receiving medical treatment (check all that apply and provide last date received):

Oxygen date: \_\_\_\_\_  Corticosteroids date: \_\_\_\_\_  Bronchodilators date: \_\_\_\_\_  Diuretics date: \_\_\_\_\_

2.  CHD: Diagnosis of hemodynamically significant congenital heart disease and ≤24 months of age (Specific Diagnosis Code \_\_\_\_\_)

Patient has the following condition: (check all that apply)

Medications for CHD: \_\_\_\_\_  Diagnosis of moderate to severe pulmonary hypertension

Date CHD medications were last received: \_\_\_\_\_  Cyanotic CHD

3. Indicate applicable risk factors:

- Congenital abnormality of airways
- Severe neuromuscular disease
- Pre-school or school-aged sibling(s) (<5 years of age)
- Family history of asthma or wheezing
- Residency in rural setting
- Daycare attendance: 2 unrelated children for >4 hours/week
- Multiple births
- Exposure to environmental tobacco smoke or air pollutants

4. Additional information:

Other medical history: \_\_\_\_\_

**Prescription Information**

Was Synagis® (palivizumab) previously administered (NICU/hospital/other location)?  No  Yes Date(s): \_\_\_\_\_

Expected date of first/next dose: \_\_\_\_\_

Deliver product to:  Office  Patient's home  Clinic Clinic Name and Location: \_\_\_\_\_

Agency nurse to visit home for injection?  No  Yes Agency name and Tax ID number: \_\_\_\_\_

**Rx**  Synagis® (palivizumab) 50 mg and/or 100 mg vials. Inject 15 mg/kg IM one time per month. QS to achieve 15 mg/kg dose. Refills: \_\_\_\_\_  
 Epinephrine 1:1000 amp. Sig: Inject 0.01 mg/kg IM/SC as directed  
 Known allergies: \_\_\_\_\_  Ancillary supplies and kits as needed for administration: \_\_\_\_\_

**Original signature of prescriber** \_\_\_\_\_ **Date** \_\_\_\_\_