



University Specialty Pharmacy
Phone 1-866-SYNAGIS
Fax 1-866-728-4810
2009-2010

Name of Case Manager Completing Form: _____

Contact Number: (____) _____

Contact E-mail: _____

Patient Information

Patient Last Name _____
 First Name _____ M.I. _____
 Parent Name(s) _____
 Street Address _____
 City _____ State _____ ZIP _____
 Phone (____) _____ Alt. Contact Phone (____) _____
 Date of Birth _____ M F
 MR# _____ Language _____

Health Insurance Information (*-Optional Fields)

PLEASE SEND A LEGIBLE COPY OF ALL INSURANCE CARDS (if avail)

Primary Insurance _____
 Plan Name _____ Telephone (____) _____
 Subscriber's Name* _____ Policy ID Number _____
 Group Number _____
 Subscriber's DOB* _____ Subscriber's Employer _____
 Secondary Insurance _____
 Plan Name _____ Telephone (____) _____
 Policy ID Number _____ Group Number _____

Treating Physician Information

Physician Name _____ Contact Name _____
 Practice Name _____
 Practice Address _____
 City _____ State _____ ZIP _____
 Phone Number (____) _____ Fax Number _____
 DEA Number _____
 Provider Number _____ NPI Number _____
 Email address _____

Primary Care Physician (PCP) Information

Physician Name _____
 Synagis coordinator _____
 Address _____
 City _____ State _____ ZIP _____
 Phone Number (____) _____ Fax Number (____) _____

2009-2010 Season

Clinical Information

PRIMARY DIAGNOSIS _____

Patient's Gestational Age (GA) _____ wks Birth Weight _____ **kg/lbs**

Current Weight _____ kg / lbs PLEASE CIRCLE ONE (e.g. kg / lbs or kg / lbs)
 Current Height _____ in/cm

Date Recorded _____

- Other Respiratory Conditions of Fetus and Newborn (770.0-770.9)
- Congenital Anomalies of Respiratory System (748)
- Other _____

MEDICAL CRITERIA

1. CLD/BPD and less than **24** months of age? Yes No
 Oxygen Date _____ Corticosteroids Date _____
 Bronchodilators Date _____ Diuretics Date _____
 Other _____
2. Congenital heart disease and less than **24** months of age? Yes No
 Diagnosis _____
 Medications for CHD _____ Last Date Received _____
 Other _____

Risk factors (check all that apply):

- Y N - Infant has one or more siblings or other children younger than 5 years living permanently in the same household
- Y N - Daycare
- Other Medical History: _____

Last Injection _____ **Start Date** (if not immed) _____

Prescribing Information

Ancillary Medication (if any): _____ Known Allergies: _____

Synagis® (palivizumab):

Sig: Inject 15 mg/kg IM Q 28-30 days X _____ months by home health nurse
 at MD Office

Prescriber's Signature _____

DATE _____