

2017-2018 Synagis® Seasonal Respiratory Syncytial Virus Enrollment Form



Fax Referral To: 1-800-323-2445

Email Referral To: customerservicefax@caremark.com

Phone: 1-800-237-2767

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION (Complete or include demographic sheet)

Patient Name: _____
 Address: _____
 City, State, ZIP: _____

Preferred Contact Method: Phone Text Email
(to primary # provided below) (to cell # provided below) (to email provided below)
Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone: _____ Home Cell Work
 Alternate Phone: _____ Home Cell Work
 DOB: _____ Gender: Male Female
 Email: _____
 Last Four of SSN: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____
 State License #: _____ NPI #: _____
 DEA #: _____

Group or Hospital: _____
 Address: _____
 City, State, ZIP: _____
 Phone: _____
 Fax: _____
 Contact Person: _____
 Contact's Phone: _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

Prescription Card: Name of Insurer: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____
 Medical Insurance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____
 Secondary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____

4 DIAGNOSIS AND CLINICAL INFORMATION Ship to: Patient Office Other: _____

Needs by Date: _____ Expected date of first injection: _____
Nursing: No nursing coordination Yes, CVS Specialty™ to coordinate home health nurse visit for injection
Diagnosis (ICD-10)
Gestational < 23 wks (P07.21) 23 wks (P07.22) 24 wks (P07.23) 25 wks (P07.24) 26 wks (P07.25) 27 wks (P07.26) 28 wks (P07.31)
Age: 29 wks (P07.32) 30 wks (P07.33) 31 wks (P07.34) 32 wks (P07.35) 33 wks (P07.36) 34 wks (P07.37) 35 wks (P07.38)

Chronic Respiratory Disease Arising in the Perinatal Period: Wilson-Mikity Syndrome (P27.0)
 Bronchopulmonary Dysplasia originating in the perinatal period (P27.1)
 Other chronic respiratory disease originating in the perinatal period (P27.8)

Congenital Abnormality of Respiratory System: Congenital Subglottic Stenosis (Q31.1) Other Congenital Malformations of Trachea (Q32.1)
 Laryngocele (Q31.3) Other Congenital Malformations of Bronchus (Q32.4)
 Other Congenital Malformations of Larynx (Q31.8) Congenital Cystic Lung (Q33.0)

Patient's Gestational Age (required): _____ weeks _____ days Patient's Birth Weight: _____ g / kg / lbs (please circle)
 Current Weight: _____ g / kg / lbs (please circle) Date Recorded: ____/____/____
 Did patient receive Synagis last season? No Yes Dates of Synagis doses given this season: _____
 Multiple births: No Yes Enter names of Synagis candidates (submit separate enrollment forms): _____
 Daycare attendance: No Yes School-age siblings in home: No Yes
 NICU history: No Yes If yes, NICU name and include NICU summary: _____
 Allergies: _____ Medical conditions not listed below: _____

Clinical Conditions	2014 AAP Committee on Infectious Disease and Bronchiolitis Guidelines
Chronic Lung Disease (CLD)	<input type="checkbox"/> < 12 months of age with CLD* <input type="checkbox"/> < 24 months of age with CLD* AND continues to require medical support during the 6-month period before second RSV season AND <input type="checkbox"/> Supplemental oxygen (dates) _____ <input type="checkbox"/> Chronic corticosteroids (drugs/dates) _____ <input type="checkbox"/> Diuretic therapy (drugs/dates) _____ <input type="checkbox"/> Bronchodilators (drugs/dates) _____ <small>*CLD of prematurely defined as gestational age < 31 weeks, 6 days AND requirement for 21% oxygen for at least the first 28 days after birth</small>
Congenital Heart Disease (CHD)	<input type="checkbox"/> < 12 months of age at start of season with hemodynamically significant CHD such as: <input type="checkbox"/> Acyanotic heart disease and receiving medication to control congestive heart failure and surgery to correct (meds/dates) _____ (surgery date) _____ <input type="checkbox"/> Moderate to severe pulmonary hypertension <input type="checkbox"/> Other: describe _____ <input type="checkbox"/> < 24 months of age undergoing cardiac transplantation during the RSV season (date) _____ <input type="checkbox"/> Cyanotic Heart Disease: diagnosis _____
Airway/Neuro-muscular Conditions	<input type="checkbox"/> < 12 months of age at start of season and compromised handling of secretions AND due to <input type="checkbox"/> Significant abnormality of the airway (attach clinical notes) <input type="checkbox"/> Neuromuscular condition (attach clinical notes)
Prematurity	<input type="checkbox"/> ≤ GA 28 wks, 6 days AND < 12 months at start of season
Other conditions	<input type="checkbox"/> Other medical history (describe) _____

5 PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DOSE & DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Synagis (palivizumab)	<input type="checkbox"/> 50 mg and/or 100 mg vials	<input type="checkbox"/> Inject 15 mg/kg IM one time per month <input type="checkbox"/> Other: _____	QS to achieve 15 mg/kg dose	
<input type="checkbox"/> Epinephrine	1:1000 amp	Inject 0.01 mg/kg sub-Q as directed for anaphylaxis		

Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

PHYSICIAN SIGNATURE REQUIRED

⑥ X _____ X _____
 PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)

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