VA Premier Health Plan, Inc.

Fax Referral To: 888-315-3270
Phone: 888-315-3395

SYNAGIS® PALIVIZUMAB

Prescription Referral Form

PATIENT INFORMATION

Patient Name: ____________________
Address: ____________________
City, State, Zip: ____________________
Home Phone: ____________________
Alternate Phone: ____________________
SS #: ____________________
Date of Birth: __________ Gender: __________
Guardian Name: ____________________

PRESCRIBER INFORMATION

Prescriber's Name: ____________________
State License #: __________ UPIN: __________
DEA #: __________ NPI #: __________
Group or Hospital: ____________________
Address: ____________________
City, State Zip: ____________________
Phone: __________ Fax: __________
Contact Person: __________ Phone: __________

INSURANCE INFORMATION *(Please copy and attach the front and back of insurance and prescription drug card)*

Primary Insurance: Subscriber: __________ ID#: __________ Name of Insurer: __________ Group: __________ Phone: __________
Secondary Insurance: Subscriber: __________ ID#: __________ Name of Insurer: __________ Group: __________ Phone: __________

CLINICAL INFORMATION

Primary Diagnosis: Patient's Gestational Age (GA): __________ weeks __________ days Birth Weight: __________ kg OR __________ lb __________ oz
Current Weight: __________ kg OR __________ lb __________ oz Date Recorded: __________

RISK FACTORS *(Please check which condition(s) apply) (*AAP [Red Book] - 2009 Risk Factors)*

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

- ☐ School-age siblings living in the same household, less than 5 yrs old*
- ☐ Daycare attendance*
- ☐ Exposure to environmental air pollutants
- ☐ Severe neuromuscular disease
- ☐ Residency in a rural setting
- ☐ Congenital abnormality of airway
- ☐ Exposure to environmental tobacco smoke
- ☐ Birth weight <2500 g
- ☐ Crowded living conditions
- ☐ Multiple birth
- ☐ Family history of asthma
- ☐ Young chronologic age ≤12 weeks
- ☐ None

Other medical history/risk factor: ____________________

MEDICAL CRITERIA *(Please check which condition(s) apply)*

PREMATURITY

ICD-9: ____________________

- ☐ Infants born ≤28 weeks and under 12 months of age at the start of the RSV season.
- ☐ Infants born between 29 weeks, 0 days and 31 weeks, 6 days of gestation and under 6 months of age at the start of the RSV season.
- ☐ Infants born between 32 weeks, 0 days and 34 weeks, 6 days of gestation and younger than 3 months of age at the start of RSV season or born during the RSV season & have one of the risk factors.

CHRONIC LUNG DISEASE

ICD-9: ____________________

- ☐ Children under 24 months of age with chronic lung disease of prematurity (bronchopulmonary dysplasia) who have received medical therapy (supplemental oxygen, bronchodilator, diuretic or corticosteroid therapy) within 6 months prior to the start of the RSV season. Please check all that applies:
  - ☐ Oxygen Date: __________
  - ☐ Corticosteroids Date: __________
  - ☐ Bronchodilator Date: __________
  - ☐ Diuretics Date: __________

HEART DISEASE

ICD-9: ____________________

- ☐ Children under 24 months of age with hemodynamically significant cyanotic or acyanotic heart disease and have any of the following:
  - ☐ Currently receiving medication to control heart failure
  - ☐ Having moderate to severe pulmonary hypertension
  - **Medications**: ____________________
  - ☐ Having cyanotic heart disease

SEVERE IMMUNO-COMPROMISED

ICD-9: ____________________

- ☐ Severe immunodeficiency - infant or child < 24 months of age at the start of the RSV season with a severe immunodeficiency (e.g., severe combined immunodeficiency or severe acquired immunodeficiency syndrome)

CONGENITAL ABNORMALITIES

ICD-9: ____________________

- ☐ Infant born before 35 weeks of gestation who have had either congenital abnormalities of the airways or a neuromuscular condition that compromises respiratory secretions.

NICU / HOSPITAL HISTORY

Did the patient spend time in the NICU or Special Care Nursery? ☐ Yes ☐ No **If yes, please attach the 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

EXPECTED DATE OF FIRST/NEXT INJECTION: __________ Injection already given? ☐ Yes Date(s): __________ ☐ No

Deliver product to: ☐ Office ☐ Patient's Home ☐ Clinic Office/Clinic Location: ____________________
Agency nurse to visit home for injection? ☐ Yes ☐ No Agency Name: ____________________

PRESCRIPTION INFORMATION

- ☐ **Synagis® (palivizumab)** 50- and/or 100-mg vials SIG: Inject 15 mg/kg IM one time per month (every 28-30 days) Dispense Quantity: QS
- ☐ **Epinephrine** 1:1000 amp SIG: Inject 0.01 mg/kg SC as directed Qty:__________
- ☐ Supplies

Refills
☐ Thru RSV Season

____
Prescriber's Signature (Date)

AXIUM HEALTHCARE PHARMACY, INC.

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