



Patient information	Prescriber + Shipping Information
Patient Name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SS #: _____ Primary Language: _____ Address: _____ Apt/Suite # _____ City: _____ State: _____ Zip: _____ Primary Phone: _____ Alternate Phone: _____ Caregiver name: _____ Relation: _____ Local Pharmacy: _____ Phone: _____ Insurance Plan: _____ Plan ID #: _____ <b>Please fax a copy of front and back of the insurance card(s).</b>	Physician Name: _____ NPI #: _____ Address: _____ Apt/Suite # _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email address: _____ Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Physician <input type="checkbox"/> Clinic: _____

Clinical Information (Please fax all pertinent clinical and lab information)	
<b>ICD-10/Diagnosis Code:</b> <input type="checkbox"/> Q20.0-Q26.4 (Congenital heart disease) <input type="checkbox"/> Q30.0-Q34.9 (Congenital anomalies of the respiratory system) <input type="checkbox"/> P27.1-P27.9 (Chronic lung disease of prematurity) <input type="checkbox"/> P22.1-P28.9 (Respiratory conditions of fetus & newborn) <input type="checkbox"/> P07.21-P07.23 (≤ 24 completed weeks of gestation) <input type="checkbox"/> P07.24-P07.25 (25-26 completed weeks of gestation) <input type="checkbox"/> P07.26-P07.31 (27-28 completed weeks of gestation) <input type="checkbox"/> P07.32-P07.38 (29-35 completed weeks of gestation) Other (please specify): _____ Secondary diagnosis, if applicable: _____	Gestational Age: _____ Birth Weight: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Current Weight: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Date Recorded: _____ Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> Other: _____ Did the patient spend time in the NICU/PICU/special care nursery? <input type="checkbox"/> Yes <input type="checkbox"/> No Discharge date: _____ (Provide discharge notes) Has Synagis® already been administered? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many doses: _____ Date(s): _____ <b>Expected Date of first/next dose:</b> _____ Agency nurse to visit home for administration? <input type="checkbox"/> Yes <input type="checkbox"/> No Agency name: _____

Medical Criteria for Determination of High-Risk Indication:
<input type="checkbox"/> Infant born before 29 weeks, 0 days gestation that is < 12 months of age at the start of the RSV season <input type="checkbox"/> Chronic lung disease (CLD) of prematurity (gestational age < 32 weeks, 0 days and a requirement for > 21% oxygen for at least the first 28 days after birth) <input type="checkbox"/> First season prophylaxis <input type="checkbox"/> Second season prophylaxis; please indicate which <u>treatment(s) and date(s)</u> the patient has received during the 6-month period before the start of the second RSV season <input type="checkbox"/> Oxygen: _____ <input type="checkbox"/> Bronchodilator: _____ <input type="checkbox"/> Corticosteroids: _____ <input type="checkbox"/> Diuretics: _____ <input type="checkbox"/> Hemodynamically significant CHD in a child ≤ 12 months of age <input type="checkbox"/> Acyanotic heart disease, receiving medication to treat CHF, and will require cardiac surgical procedures Please list all medications the patient is receiving for treatment of this condition: _____ Last date received: _____ <input type="checkbox"/> Moderate to severe pulmonary hypertension <input type="checkbox"/> Cyanotic heart defect ( <i>pediatric cardiology consult required</i> )

Other Relevant Information for Consideration:
<input type="checkbox"/> Diagnosis of Down syndrome with qualifying heart disease, CLD, airway clearance issues, or prematurity (< 29 weeks, 0 days gestation) <input type="checkbox"/> <12 months with neuromuscular disease or congenital anomaly impairing airway secretion clearing <input type="checkbox"/> <12 months with CF and clinical evidence of CLD and/or nutritional compromise <input type="checkbox"/> <24 months and undergoing cardiac transplantation during RSV season <input type="checkbox"/> <24 months and profoundly immunocompromised during RSV season <input type="checkbox"/> <24 months with CF and manifestations of severe lung disease (previous hospitalization for pulmonary exacerbation in first year of life or abnormalities on chest radiography or chest computed tomography that persist when stable) or weight-for-length less than the 10th percentile <input type="checkbox"/> Other (please specify): _____

Prescription
<input type="checkbox"/> <b>Synagis® (palivizumab)</b> 50 mg and/or 100 mg vials Inject 15 mg/kg intramuscularly once monthly Qty: <input type="checkbox"/> Sufficient to achieve 15 mg/kg <input type="checkbox"/> Other: _____ Refills: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> <b>Epinephrine</b> 1:1000 ampule Inject 0.01 mg/kg subcutaneously as directed Qty: <input type="checkbox"/> Sufficient to achieve 0.01 mg/kg <input type="checkbox"/> Other: _____

Prescriber's Signature: _____	Date: _____
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I authorize Rx International Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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