Americare PS™ PHARMACEUTICAL SERVICES

Synagis Referral 2019-20 Season

Americareps.com

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PATIENT INFORMATION	PRESCRIBER INFORMATION
	Prescriber's Name: ______
Patient Name: ______	Specialty: ______
Address: ______	Address: ______
City, State, Zip ______	City, State, Zip: ______
Primary Phone: ______ ☐ Home ☐ Cell ☐ Work	NPI: ______ Office Contact: ______
Alternate Phone: ______ ☐ Home ☐ Cell ☐ Work	Clinic Name ______
DOB: ______ GENDER : ☐ Male ☐Female	Phone: ______ Fax: ______
Primary Language: ______	NICU Hospital: ______ NICU MD: ______
Email: ______	NICU Tel#: ______
Parent/Guardian: ______	NICU Contact: ______

1. What is the patient's diagnosis?
   - Prematurity
   - Chronic lung disease of prematurity
   - Congenital heart disease (CHD)
   - Congenital abnormality of the airway
   - Neuromuscular condition
   - Other______

2. What is the ICD-10 code:______
   (If patient's diagnosis is anything other than chronic lung disease (CLD) of prematurity, skip to question #5)

3. Did the patient require greater than 21% oxygen for at least the first 28 days after birth? Yes No

4. Which of the following has the patient been treated with during the 6 month period prior to the start of the RSV season?
   - Oxygen
   - Diuretics
   - Chronic Corticosteroid
   - Other______
   - None of the above

5. What is the gestational age?______ weeks, ______ days

6. What is the chronological age (months) at the start of RSV season? *Note: If infant was born on or after the season start date, indicate zero.* ______

7. Is Synagis being used to prevent serious lower respiratory tract disease caused by RSV? Yes No

8. Is this an off-season request for Synagis? Yes No

9. How many doses of Synagis has the patient received this RSV season?______

10. *If this is off-season request for Synagis*, according to the CDC National Respiratory and Enteric Virus Surveillance System (NREVESS), is the RSV activity greater than or equal to 10% for the requested region within 2 weeks of the intended dose? Yes No

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Chronic Lung Disease of Prematurity

11. *If chronological age at the start of RSV season is less than 12 months*, has the patient received Synagis for the previous RSV season? Yes No

Section B: Congenital Heart Disease (CHD)

12. Is the CHD hemodynamically significant? Yes No

13. *If chronological age at the start of RSV season is greater than or equal to 12 months to less then 24 months*, is there a possibility that the patient will be undergoing cardiac transplantation during RSV season? Yes No

Section C: Congenital Abnormality of the Airway, Neuromuscular Condition

14. Does the patient's condition compromise handling of respiratory secretions? Yes No

Gestational Age ICD-10 code

Weeks	Code
<23 weeks	P07.21
23 weeks	P07.22
24 weeks	P07.23
25 weeks	P07.24
26 weeks	P07.25
27 weeks	P07.26
28 weeks	P07.31
29 weeks	P07.32
30 weeks	P07.33
31 weeks	P07.34
32 weeks	P07.35
33 weeks	P07.36
34 weeks	P07.37
35 weeks	P07.38
36 weeks	P07.39

Insurance Information

Medicaid ID # ______

HMO Name______

HMO ID #______

Pertinent Information

Current weight______ kg lbs

Date recorded______

Multiple births? Yes No
Enter names of Synagis candidates below
(submit separate enrollment forms)

Shipment Information

Ship to: Patient home
Prescriber's office
Other
Address if different from prescriber's
______
______

Will the patient be receiving medication via a visiting nurse at home? Yes No
(Please note: Americare does not coordinate homecare.)

PRESCRIPTION INFORMATION *(This is not a valid prescription. Please escribe or fax Official NYS Prescription to us.)*

Medication	Dose/Strength	Directions	Quantity	Refills
☐ Synagis® (palivizumab)	50 and/or 100mg vials	Inject 15mg/kg IM once per month	QS to achieve 15mg/kg/dose	
☐ Epinephrine	1:1000 vial	Inject 0.01mg/kg SQ prn anaphylaxis	1ml	

I have chosen Americare Pharmaceutical Services Inc. NPI 1679678049, and its employees as an Authorized Agent to assist my staff in handling many of the responsibilities associated with fulfilling the medication requirements of my patients, including specialty medications. These responsibilities include but are not limited to, requesting Prior Authorizations for my patients, answering the criteria questions for the coverage determination within the Prior Authorization Request forms, receiving the Prior Authorization determination from PBMs, as well as any other duties or requirements needed to properly perform a Prior Authorization for my patients. As my Authorized Agent, Americare Pharmaceutical Services, Inc. has been provided all of the required information to accurately complete Prior Authorizations.

X ______ Primary care physician signature

X ______ NICU MD