



# Respiratory Syncytial Virus (RSV) Enrollment Form 2022-2023

Date Needed \_\_\_\_\_ Please complete this form and fax to 866.823.9681

## PATIENT INFORMATION (Please print or type clearly)

Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Phone Numbers (Include Area Code): Day \_\_\_\_\_  
 Night \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  Male  Female  
 Allergies \_\_\_\_\_  
 Primary Caregiver \_\_\_\_\_ Phone \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

## INSURANCE INFORMATION (Include copies of insurance card - front and back):

Primary Insurance \_\_\_\_\_ Phone \_\_\_\_\_  
 Name of Cardholder \_\_\_\_\_  
 ID # \_\_\_\_\_ Group # \_\_\_\_\_

## DELIVERY INSTRUCTIONS:

Physician  \_\_\_\_\_ Other \_\_\_\_\_  
 \_\_\_\_\_ Address \_\_\_\_\_  
 \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## PRESCRIBER INFORMATION \*Indicates Required Field

Prescriber First and Last Name\* \_\_\_\_\_  
 NPI #\* \_\_\_\_\_ DEA # \_\_\_\_\_  
 Facility Name \_\_\_\_\_  
 Street Address\* \_\_\_\_\_  
 City\* \_\_\_\_\_ State\* \_\_\_\_\_ Zip Code\* \_\_\_\_\_  
 Phone #\* \_\_\_\_\_ Fax # \_\_\_\_\_  
 Form Submitted By \_\_\_\_\_

## CONTACT:

Healthcare Professional \_\_\_\_\_ Phone # \_\_\_\_\_

## 3. CLINICAL INFORMATION & MEDICAL ASSESSMENT

Patient's Gestational Age: weeks \_\_\_\_\_ days \_\_\_\_\_ Birth Weight \_\_\_\_\_ g/kg/lbs  
 Current Weight \_\_\_\_\_ g/kg/lbs Date Recorded: \_\_\_\_\_

**Please document all diagnoses and provide the specific ICD-10 code for each.**

- Prematurity: Infants younger than 12 months of age at the start of RSV season and who were born at or before 28 weeks, 6 days gestation  
 ICD-10 (P07.21 through P07.31, please indicate): \_\_\_\_\_
- Diagnosis of chronic lung disease (CLD) and younger than 12 months of age?  
 Yes\*  No ICD-10: \_\_\_\_\_  
 Yes  No Gestational Age ≤ 31 weeks, 6 days  ICD-10: \_\_\_\_\_  
 Yes\*  No Patient required >21% oxygen for at least the first 28 days after birth  
 Yes\*  No Patient is 12 to 24 months of age, meets all CLD requirements above and continues to require medical support for CLD within 6 months of the start of RSV season (check all that apply and provide last date received):  
 Oxygen (Date): \_\_\_\_\_  Corticosteroids (Date): \_\_\_\_\_  
 Diuretics (Date): \_\_\_\_\_

Prescriber's Signature \_\_\_\_\_ Date \_\_\_\_\_

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## CLINICAL INFORMATION & MEDICAL ASSESSMENT (CONT'D)

- Patient is 12 months of age or younger with hemodynamically significant congenital heart disease  Yes\*  No  
 Patient has the following condition(s):  
 Diagnosis of moderate-severe pulmonary hypertension ICD-10: \_\_\_\_\_  
 Cyanotic heart disease (in consultation with a pediatric cardiologist) ICD-10: \_\_\_\_\_  
 Acyanotic heart disease (receiving medication to control CHF & will require cardiac surgical procedures) – ICD-10: \_\_\_\_\_  
 Medications to control CHF: \_\_\_\_\_  
 Last date received: \_\_\_\_\_
- Patient is younger than 24 months of age and has undergone cardiac transplantation during the RSV season.  Yes\*  No  
 Date of Transplant: \_\_\_\_\_
- Neuromuscular Disease/Congenital Airway Abnormality with impaired ability to clear secretions from upper airway during first year of life:  Yes\*  No  
 Severe neuromuscular disease ICD-10: \_\_\_\_\_  
 Congenital or other pulmonary abnormality ICD-10: \_\_\_\_\_
- Profoundly immunocompromised or receiving chemotherapy during RSV season and younger than 24 months of age.  Yes\*  No  
 ICD-10: \_\_\_\_\_ Drug Regimen: \_\_\_\_\_
- Patient has a diagnosis of Cystic Fibrosis as well as:  
 Clinical evidence of CLD (under 12 months of age)\*  
 Nutritional compromise (under 12 months of age)\*  
 Manifestations of severe lung disease (12-24 months of age)\*  
(Previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest radiography or chest computed tomography that persist when stable.)  
 Weight for length less than 10<sup>th</sup> percentile (12-24 months of age)\*

## NICU HISTORY:

Did the patient spend time in the NICU?  Yes  No  
 If yes, please attach the NICU Discharge Summary  
 Was there a NICU/HOSPITAL RSV dose administered?

Yes – Date(s): \_\_\_\_\_  No  
 Agency nurse to visit home for injection?  Yes  No

Agency Name: \_\_\_\_\_

**\*PLEASE PROVIDE CLINICAL DOCUMENTATION WHERE REQUESTED**

## RX

- Synagis® (palivizumab): Combination of 50- and/or 100-mg vials  
 Sig: Inject 15 mg/kg IM one time per month  
 Dispense Quantity: QS Refill x 4 months
  - Epinephrine 1:1000 amp. Sig: Inject 0.01 mg/kg as directed  
 (dispense only if Synagis® is administered in the home)
  - Other: \_\_\_\_\_
- EXPECTED DATE OF FIRST/NEXT INJECTION:** \_\_\_\_\_  
 Previous injection(s) given?  Yes  No  
 Please list all previous injection dates: \_\_\_\_\_