Respiratory Syncytial Virus (RSV) Enrollment Form 2016-2017

Date Needed ________________ **Please complete this form and fax to 866.823.9681**

1. 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 ____________

2. 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.

1. 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): ____________________
2. 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):____________

CLINICAL INFORMATION & MEDICAL ASSESSMENT (CONT'D)

3. 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: ________________
4. Patient is younger than 24 months of age and has undergone cardiac transplantation during the RSV season. ❑ Yes* ❑ No
   Date of Transplant: ____________________
5. 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: ______________
6. Profoundly immunocompromised or receiving chemotherapy during RSV season and younger than 24 months of age. ❑ Yes* ❑ No
   ICD-10: ____________ Drug Regimen: ____________________
7. 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 10th percentile (12-24 months of age)*

4. 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 _______months **(required)**

❑ Other: ____

EXPECTED DATE OF FIRST/NEXT INJECTION:____________________
Previous injection(s) given? ❑ Yes ❑ No
Please list all previous injection dates: ________________________

Prescriber's Signature ____ Date ________________

I authorize Amber Pharmacy and its representatives to act as my agent to initiate and execute the insurance prior authorization process and, in doing so, to release clinical information via phone or fax to the appropriate PBM.

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, and proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. 082212

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