



Respiratory Syncytial Virus (RSV) Enrollment Form 2017-2018

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.

- 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 \leq 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)

- 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 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: OS 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