Respiratory Syncytial Virus (RSV) Enrollment Form 2018-2019

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 4 months **(required)**

❑ 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: _____

Prescriber's Signature _____ Date _____