2023-2024 Synagis Seasonal Respiratory Syncytial Virus Enrollment Form

CVS specialty®

Fax Referral To: 1-888-280-1191 OR 787-759-4161
Address: 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927

Phone: 1-888-280-1190 OR 787-759-4162
NCPDP: 4026325

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ DOB: _____ Gender: ☐ Male ☐ Female
Address: _____City, State, ZIP Code: _____
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: _____ Alternate Phone: _____
Email: _____ Last Four of SSN: _____ Primary Language: _____
If **Minor**, Parent/Caregiver/Guardian Name (Last, First): _____ **Relationship to minor**: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____
NPI #: _____ DEA #: _____ Group or Hospital: _____
Address: _____ City, State, ZIP Code: _____
Phone: _____ Fax: _____ Contact Person: _____ Contact's Phone: _____

3 INSURANCE INFORMATION

Please fax copy of prescription and insurance cards with this form, if available (front and back)

Prescription Card:
Name of Insurer: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____
Medical Insurance:
Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____
Secondary Insurance:
Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Expected date of first injection: _____ Ship to: ☐ Patient ☐ Office ☐ Other: _____

Diagnosis (ICD-10):

Gestational Age:
☐ < 23 wks (P07.21) ☐ 23 wks (P07.22) ☐ 24 wks (P07.23) ☐ 25 wks (P07.24)
☐ 26 wks (P07.25) ☐ 27 wks (P07.26) ☐ 28 wks (P07.31) ☐ 29 wks (P07.32)
☐ 30 wks (P07.33) ☐ 31 wks (P07.34) ☐ 32 wks (P07.35) ☐ 33 wks (P07.36)
☐ 34 wks (P07.37) ☐ 35 wks (P07.38)

Nursing:
☐ No nursing coordination ☐ Yes, CVS Specialty to coordinate home health nurse visit for injection

Chronic Respiratory Disease Arising in the Perinatal Period:
☐ Wilson-Mikity Syndrome (P27.0)
☐ Bronchopulmonary Dysplasia originating in the perinatal period (P27.1)
☐ Other chronic respiratory disease originating in the perinatal period (P27.8)

Congenital Abnormality of Respiratory System:
☐ Congenital Subglottic Stenosis (Q31.1)
☐ Laryngocele (Q31.3)
☐ Other Congenital Malformations of Larynx (Q31.8)
☐ Other Congenital Malformations of Trachea (Q32.1)
☐ Other Congenital Malformations of Bronchus (Q32.4)
☐ Congenital Cystic Lung (Q33.0)

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Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____
Prescriber Name: _____ Prescriber Phone: _____

4 DIAGNOSIS AND CLINICAL INFORMATION continued

Patient's Gestational Age (required): _____ weeks _____ days Patient's Birth Weight: _____ g / kg / lbs (please circle)
Current Weight: _____ g / kg / lbs (please circle) Date Recorded: ____/____/_____
Did patient receive Synagis last season? ☐ No ☐ Yes Dates of Synagis doses given this season: _____
Multiple births: ☐ No ☐ Yes Enter names of Synagis candidates (submit separate enrollment forms): _____
Daycare attendance: ☐ No ☐ Yes School-age siblings in home: ☐ No ☐ Yes
NICU history: ☐ No ☐ Yes If yes, NICU name and include NICU summary: _____
Allergies: _____ Medical conditions not listed below: _____

Clinical Conditions: 2014 AAP Committee on Infectious Disease and Bronchiolitis Guidelines

Chronic Lung Disease (CLD):

☐ < 12 months of age with CLD*
☐ < 24 months of age with CLD* AND continues to require medical support during the 6-month period before second RSV season
AND ☐ Supplemental oxygen (dates) _____ ☐ Chronic corticosteroids (drugs/dates) _____
☐ Diuretic therapy (drugs/dates) _____ ☐ Bronchodilators (drugs/dates) _____

*CLD of prematurely defined as gestational age < 31 weeks, 6 days AND requirement for 21% oxygen for at least the first 28 days after birth

Congenital Heart Disease (CHD):

☐ < 12 months of age at start of season with hemodynamically significant CHD such as:
- ☐ Acyanotic heart disease and receiving medication to control congestive heart failure and surgery to correct (meds/dates) _____ (surgery date) _____
- ☐ Moderate to severe pulmonary hypertension
- ☐ Other: describe _____

☐ < 24 months of age undergoing cardiac transplantation during the RSV season (date) _____
☐ Cyanotic Heart Disease: diagnosis _____

Airway/Neuro-muscular Conditions:

☐ < 12 months of age at start of season and compromised handling of secretions AND due to
☐ Significant abnormality of the airway (attach clinical notes) ☐ Neuromuscular condition (attach clinical notes)

Prematurity: ☐ < GA 28 wks, 6 days AND < 12 months at start of season

Other conditions: ☐ Other medical history (describe) _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Synagis (palivizumab)	50 mg and/or 100 mg vials	☐ Inject 15 mg/kg IM one time per month ☐ Other: _____	Quantity: QS to achieve 15 mg/kg dose Refills: _____
☐ Epinephrine	1:1000 amp	Inject 0.01 mg/kg SC as directed for anaphylaxis	Quantity: _____ Refills: 0

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute **Prescriber's Signature: _____Date: _____**	May Substitute / Product Selection Permitted / Substitution Permissible **Prescriber's Signature: _____Date: _____**

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" _____ **ATTN: New York and Iowa providers,** please submit electronic prescription

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.