

SYNAGIS ENROLLMENT FORM

Nursing Specialties, Inc.
 Fax form to: (314) 842-8486
 Questions? Call: (314) 842-8484



PATIENT INFORMATION

Last Name			First Name			Middle Initial		
Street Address			City/State/Zip Code					
Day Telephone (+Area Code)			Night Telephone (+Area Code)					
Date of Birth			Social Security Number			Sex <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> (One)		
Parent/Guardian Name								



INSURANCE INFORMATION

Please include copies of the patient's insurance cards (front & back) when faxing the referral to expedite benefit clearance.

Primary Medical Insurance		Secondary Medical Insurance	
Cardholder Name & Social Security Number (If Not Patient)		Cardholder Name & Social Security Number (If Not Patient)	
Group/Policy Number		Group/Policy Number	
Insurance Telephone Number (+Area Code)		Insurance Telephone (+Area Code)	
Employer		Medicaid Number	



PHYSICIAN INFORMATION

Prescriber's Name		Office Contact Name	
Address		City/State/Zip	
NPI #		DEA Number	
Telephone Number (+Area Code)		Fax Number (+Area Code)	
Prescriber's License Number		Medicaid License Number	

CLINICAL INFORMATION

PRIMARY DIAGNOSIS:

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

Please document all diagnoses and document to the highest degree of ICD detail

- Congenital Heart Disease _____ please specify (enter ICD9)
- Chronic Respiratory Disease Arising in the Perinatal Period (CLD) (770.7)
- ≤24 weeks of gestation (765.21 – 765.22)
- 25-26 weeks of gestation (765.23)
- 27-28 weeks of gestation (765.24)
- 29-30 weeks of gestation (765.25)
- 31-32 weeks of gestation (765.26)
- 33-34 weeks of gestation (765.27)
- 35-36 weeks of gestation (765.28)
- 37 or more weeks of GA (765.29)
- Congenital Abnormality of Respiratory System (748)
- Other Respiratory Conditions of Fetus and Newborn (770.0 – 770.9)
- Other _____ Secondary diagnosis (if applicable) _____

MEDICAL CRITERIA:

- Diagnosis of Chronic Pulmonary Disease (CLD/BPD) and < 24 months of age? Yes No ICD-9: _____
 Is patient receiving medical treatment of (✓ all that apply and provide last date received): Oxygen Date: _____
 Corticosteroids Date: _____ Bronchodilator Date: _____ Diuretics Date: _____
- Diagnosis of hemodynamically significant congenital heart disease and < 24 months of age? Yes No ICD-9: _____
 Patient has the following condition(s):
 Diagnosis of moderate-severe pulmonary hypertension
 Cyanotic heart disease
 Medications for CHD: _____ Last date received: _____
- Clinically has the following risk factors (✓ all that apply)
 Yes No School-age siblings Yes No Birth weight < 2500 g
 Yes No Daycare attendance Yes No Crowded living conditions
 Yes No Exposure to environmental air pollutants Yes No Multiple birth
 Yes No Severe neuromuscular disease Yes No Family history of asthma
 Yes No Congenital abnormality of airway Yes No Distance to healthcare provider
 Yes No Exposure to environmental tobacco smoke Yes No Young chronologic age ≤ 12 weeks

Other medical history: _____

NICU/HOSPITAL HISTORY:

- Did the patient spend time in the NICU or Special Care Nursery? Yes No
 If yes, please attach the Discharge Summary
 Was RSV prophylaxis recommended by the NICU/HOSPITAL physicians for this patient? Yes No
 Was there a NICU/HOSPITAL dose administered? Yes Date(s): _____ No

EXPECTED DATE OF FIRST/NEXT INJECTION: _____ Injection already given? Yes Date(s): _____ No

Deliver product to: Office Patient's Home Clinic Clinic Location _____
 Agency nurse to visit home for injection: Yes No Agency Name: _____

Rx

Synagis® (palivizumab) 50 and/or 100 mg vials
 Sig: Inject 15mg/kg IM one time per month (every 28-30 days)
 Dispense Quantity: QS Refill Monthly: _____ months
 Epinephrine 1:1000 amp. Sig: Inject 0.01 mg/kg as directed Known Allergies _____

Prescriber's Signature _____

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