ACRO PHARMACEUTICAL SERVICES
A PREMIER INC. COMPANY

www.acropharmacy.com

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SYNAGIS (RSV)® AMERIHEALTH ENROLLMENT FORM

Today's Date:_____
Needed By:_____

Last update 10.31.2018

COMMCARE SPECIALTY PHARMACY
A PREMIER INC. COMPANY

www.commcarepharmacy.com

Plantation, FL
Phone: 888.203.7973
Fax: 888.203.7980
NCPDP: 1079638
NPI: 1598762015

Patient Demographics:(Please provide the following or attach demographics sheet)
Patient Name:_____
Address:_____
City, State, Zip:_____
Preferred Phone:_____ Alt. Phone:_____
Last four digits of SS#:_____ Date of Birth:_____
Gender:_ Allergies:_____Height:_____ Weight:_____

Provider Office: (Please provide as much information as possible)
Prescriber's Name:_____ Group/Hospital: _____
Specialty:_____ License#:_____Tax ID#:_____
Address:_____
NPI:_____ DEA:_____
City, State, Zip:_____
Phone:_____ Fax:_____ Office Contact:_____

Insurance Information: (Please copy and attach the front and back of the patient's insurance card)

Medication Delivery to: (choose one) □Patient's Address □Always to Physician's Office □First fill to Physician's Office, refills to Patient's Address

Medical Criteria (Please attach clinical documentation for all diagnoses below)

1. **Bronchiolitis RSV Hospitalization?** ❑Yes ❑No
2. **Diagnosis of Chronic Lung Diseases (CLD) of prematurity?** ❑Yes ❑No **ICD-10: _____**
   - ❑Oxygen: Concentration: _____ Dates: _____
   - ❑Supporting Clinical Documents are attached for Oxygen Use
   - ❑Bronchodilator Dates: ___ /___ /___ ❑Corticosteroids Dates: ___ /___ /___ ❑Diuretics Dates: ___ /___ /___
3. **Diagnosis of Hemodynamically Significant Congenital Heart Disease?** ❑Yes ❑No **ICD-10: _____**
   Please include letter from Cardiologist. Patient has the following conditions:
   - ❑Diagnosis of Moderate-Severe Pulmonary Hypertension
   - ❑Medications for CHF (list): _____ Date last received: ___ /___ /___
   - Recent Surgical Procedure Requiring Cardiopulmonary Bypass
     - ❑Yes ❑No – If yes, an additional post-operative dose of palivizumab may be medically necessary
4. **Diagnosis of Cystic Fibrosis with one of the following risk factors?** ❑Yes ❑No **ICD-10: _____**
   - ❑Clinical Evidence of CLD ❑Nutritional Compromise ❑Weight for length less than 10th percentile
   - ❑Manifestations of severe lung disease (previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest radiography or chest computed tomography that persist when stable)
5. **Diagnosis of profound immunocompromise?** ❑Yes ❑No Reason: _____ **ICD-10: _____**
6. **Diagnosis of Congenital Abnormalities of the airway and 12 months of age or less?** ❑Yes ❑No **ICD-10: _____**
7. **Neuromuscular condition that compromises handling of respiratory secretions and 12 months of age or less?** ❑Yes ❑No **ICD-10: _____**

Patient's Gestational Age: __ weeks ___days
ICD-10: _____
Birth Weight: _____ g/ kg / lbs
Current Weight: _____ g/ kg / lbs
Date Recorded: _____

NICU History
❑Yes ❑No
NICU Name: _____
Please Attach the NICU Discharge Summary
Was there a NICU Dose Administered?
❑Yes ❑No Dates: ____ / ____ /____

Rx
❑SYNAGIS (palivizumab) 50 mg and/or 100 mg Vials
Sig: Inject 15 mg/kg IM One Time per Month
Dispense Quantity: QS
Refills Through: ____ / ____ /____

Other Rx
❑ _____
❑ _____

Expected Date of First/Next Injection:
___ / ____ / ____
Previous Injections? ❑Yes ❑No
Dates: _____

❑Parent/Caregiver contact:
_____
❑Parent/Caregiver has been contacted, and we have been granted permission to contact.

Unless otherwise noted this prescription authorizes Acro and Commcare to dispense & share information between each other to optimize care delivery. Check here to restrict to □Acro □Commcare

Physician Signature:_____ □DAW (Dispense as Written) **Date:**_____

Patient Support Programs: I authorize **Acro Pharmaceutical Services and Commcare Specialty Pharmacy** to enroll me in company-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to injection training. I further authorize the release to communicate to the corresponding manufacturer the minimum necessary information about my health condition and prescription(s) to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis or other commercial purposes, and provide educational information regarding therapies. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. However, I will not be enrolled in the service program listed above. A copy of this authorization will be utilized with the same effectiveness as an original. Ancillary supplies provided as needed for administration.

***Patient Signature:** (required for participation)_____ Date:_____ □ Please select if you would like the patient enrolled in a Manufacturer's Assistance Program