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SYNAGIS (RSV)[®] INDEPENDENCE BLUE CROSS ENROLLMENT FORM

Today's Date: _____
 Needed By: _____

Last update 10.31.2018



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)

- Bronchiolitis RSV Hospitalization?** Yes No
- 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: ___/___/___
- 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
- 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)
- Diagnosis of profound immunocompromise?** Yes No Reason: _____ ICD-10: _____
- Diagnosis of Congenital Abnormalities of the airway and 12 months of age or less?** Yes No ICD-10: _____
- 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

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