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SPASSIST®
SYNAGIS (RSV)®
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)

1. ❑**BPD/ CLDP: Diagnosis of bronchopulmonary dysplasia/ Chronic Lung Diseases (CLD) of prematurity** **(Specific Diagnosis Code: _________)**

   Is patient receiving medical treatment? (check all that apply and provide last date received)

   ❑Oxygen Date: ____________________

   ❑Corticosteroids Date: ____________________

   ❑Bronchodilators Date: ____________________

   ❑Diuretics Date: ____________________

2. ❑**CHD: Diagnosis of Hemodynamically Significant Congenital Heart Disease (CHD)** **(Specific Diagnosis Code: _________)**

   Patient has any of the following conditions:

   ❑Diagnosis of Moderate to Severe Pulmonary Hypertension

   ❑Cyanotic CHD

   ❑Medications for CHD (list): ____________________

   ❑Date CHD medications were last received: ____________________

3. **Indicate applicable risk factors:**

   ❑Congenital abnormality of airways ❑Severe neuromuscular disease ❑Pre-school or school-aged sibling(s) (<5 years of age)

   ❑Family history of asthma or wheezing ❑Residency in rural setting ❑Daycare- care at any home or facility

   ❑Multiple births ❑ Exposure to environmental tobacco smoke or air pollutants

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

❑Epinephrine 1:1000 amp

Sig: Inject 0.01 mg/kg IM/SQ as directed

❑ ____________________

Expected Date of First/Next Injection:

___ / ____ / ____

Previous Injections? ❑Yes ❑No

Dates: ____________________

❑Parent/Caregivers have 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 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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