

CVS Caremark Connect:
Phone: 800-237-2767 Fax: 800-323-2445

Or if preferred, fax referral to MedImmune's
RSV Connection™ Fax: 866-252-1749

Date: _____
Needs by Date: _____

Ship to: Patient Office Other: _____

PATIENT INFORMATION

(Complete the following or send patient demographic sheet)

Patient Name: _____
Address: _____
City, St., Zip: _____
County: _____
Home Phone: _____ Alternate Ph.: _____
SS #: _____ Primary Language: _____
Date of Birth: _____ Gender: _____
Parent/Guardian Name: _____

PRESCRIBER INFORMATION

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

INSURANCE INFORMATION (Please copy and attach the front and back of insurance and prescription drug card)

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

Diagnosis (Required): ATTACH NICU DISCHARGE SUMMARY

< 24 weeks of gestation (765.21) 29-30 weeks of gestation (765.25) 37 weeks+ of gestation (765.29) Congenital Heart Disease (Specify ICD-9) _____
 24 weeks of gestation (765.22) 31-32 weeks of gestation (765.26) Chronic Respiratory Disease arising in the perinatal period (CLD) (770.7)
 25-26 weeks of gestation (765.23) 33-34 weeks of gestation (765.27) Congenital Abnormality of Respiratory System (748.3-748.4)
 27-28 weeks of gestation (765.24) 35-36 weeks of gestation (765.28) Other: _____

Patient Evaluation:

• Patient's gestational age (Required): _____ weeks _____ days • Current Weight: _____ g/kg/lbs • Date Recorded: _____
• Chronic Lung Pulmonary Disease** (CLD/BPD) and less than 24 months at start of RSV Season? Yes No ICD-9: _____
** Chronic Lung Disease is generally defined: • For infants <32 weeks: Oxygen requirement at 36 weeks gestation age or at discharge.
• For infants ≥ 32 weeks: Oxygen requirement at age 28 days or greater or at discharge.
• Treatment for CLD within 6 months of onset of RSV season with: Oxygen Start Date: _____ End Date: _____ Diuretics Start Date: _____ End Date: _____
 Corticosteroids Start Date: _____ End Date: _____ Bronchodilator Start Date: _____ End Date: _____
• Diagnosis of congenital heart disease (CHD) and less than 24 months at start of season? Yes No ICD-9: _____
Is CHD hemodynamically significant at this time? Yes No
• Patient has the following conditions: (Check One)
 Diagnosis of Moderate-Severe Pulmonary Hypertension Cyanotic Heart Disease Acyanotic Heart Disease Surgery to correct CHD Date surgery performed/planned: _____
 Medications to control CHF (list): _____ Start Date: _____ End Date: _____
• Significant congenital abnormality of the airway OR neuromuscular condition AND less than 12 months at start of season? Yes No ICD-9: _____
Does condition cause compromised handling of secretions? Yes No
• Prematurity: Gestational age of ≤ 28 weeks, 6 days AND less than 12 months at the start of season
 Gestational age of 29 weeks, 0 days – 31 weeks, 6 days AND less than 6 months at the start of season
 Gestational age of 32 weeks, 0 days – 34 weeks, 6 days with the following risk factor(s) AND less than 3 months at the start of season:
• Siblings/children less than 5 years old living in the same household: Name: _____ DOB: _____
Name: _____ DOB: _____
 Child care attendance (defined as 2 or more unrelated children > 4 hours per week) Date started: _____ OR will start: _____ Daycare name: _____
• Multiple births? Yes No • Names of sibling RSV candidates (please submit separate enrollment form) _____
• NICU History: Yes No • If yes, NICU name: _____ • Was this season's first Synagis dose given in the NICU? Yes No • If yes, date(s): _____
• Previous injections? Yes No • If yes, dates: _____ • Expected date of first/next injection: _____
• List Allergies: _____ • Other medical history and/or Risk Factors: _____
(Please include NICU summary)

Home Health Coordination:

• Specialty Pharmacy to coordinate injection training/home health nurse visit as necessary. Yes No *Agency of choice: _____

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Synagis® (palivizumab)	<input type="checkbox"/> 50 and/or 100mg vials	<input type="checkbox"/> Inject 15mg/kg IM one time per month <input type="checkbox"/> Other: _____	QS to achieve 15mg/kg dose	
<input type="checkbox"/> Epinephrine (when required for home administration)	1:1000 amp	Inject 0.01mg/kg subcutaneously as directed for anaphylaxis		

Ancillary Supplies and Kits Provided As Needed for Administration

Prescriber has counseled parent/guardian on Synagis therapy and CVS Caremark may contact parent/guardian

X _____ **X** _____
PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)

Note: The phone number on your fax-back referral confirmation letter will show the CVS Caremark pharmacy contact information for this patient. Please make note of it.
** American Academy of Pediatrics and The American College of Obstetricians and Gynecologists. Bronchopulmonary Dysplasia. Guidelines for Perinatal Care: 6th Edition. 2008; 273-276.