Synagis Referral 2018-19 Season

Americareps.com

317 Nassau Boulevard, Garden City, NY 11530
t-516-292-7788 f-516-292-5103
Specialty@americareps.com

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip _____
Primary Phone: _____ ☐ Home ☐ Cell ☐ Work
Alternate Phone: _____ ☐ Home ☐ Cell ☐ Work
DOB: _____ GENDER : ☐ Male ☐ Female
Primary Language: _____
Email: _____
Parent/Guardian: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
Specialty: _____
Address: _____
City, State, Zip: _____
NPI: _____ Office Contact: _____
Clinic Name _____
Phone: _____ Fax: _____
NICU Hospital: _____ NICU MD: _____
NICU Tel#: _____
NICU Contact: _____

1. What is the patient's diagnosis?
   - ☐ Prematurity
   - ☐ Chronic lung disease of prematurity
   - ☐ Congenital heart disease (CHD)
   - ☐ Congenital abnormality of the airway
   - ☐ Neuromuscular condition
   - ☐ Other_____

2. What is the ICD-10 code:_____
   (If patient's diagnosis is anything other than chronic lung disease (CLD) of prematurity, skip to question #5)

3. Did the patient require greater than 21% oxygen for at least the first 28 days after birth? ☐ Yes ☐ No

4. Which of the following has the patient been treated with during the 6 month period prior to the start of the RSV season?
   - ☐ Oxygen
   - ☐ Diuretics
   - ☐ Chronic Corticosteroid
   - ☐ Other_____
   - ☐ None of the above

5. What is the gestational age?_____ weeks, _____ days

6. What is the chronological age (months) at the start of RSV season? *Note: If infant was born on or after the season start date, indicate zero.* _____

7. Is Synagis being used to prevent serious lower respiratory tract disease caused by RSV? ☐ Yes ☐ No

8. Is this an off-season request for Synagis? ☐ Yes ☐ No

9. How many doses of Synagis has the patient received this RSV season?_____

10. *If this is off-season request for Synagis,* according to the CDC National Respiratory and Enteric Virus Surveillance System (NREVESS), is the RSV activity greater than or equal to 10% for the requested region within 2 weeks of the intended dose? ☐ Yes ☐ No

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Chronic Lung Disease of Prematurity

11. *If chronological age at the start of RSV season is less than 12 months,* has the patient received Synagis for the previous RSV season? ☐ Yes ☐ No

Section B: Congenital Heart Disease (CHD)

12. Is the CHD hemodynamically significant? ☐ Yes ☐ No

13. *If chronological age at the start of RSV season is greater than or equal to 12 months to less then 24 months*, is there a possibility that the patient will be undergoing cardiac transplantation during RSV season? ☐ Yes ☐ No

Section C: Congenital Abnormality of the Airway, Neuromuscular Condition

14. Does the patient's condition compromise handling of respiratory secretions? ☐ Yes ☐ No

Gestational Age ICD-10 code

- ☐ <23 weeks P07.21
- ☐ 23 weeks P07.22
- ☐ 24 weeks P07.23
- ☐ 25 weeks P07.24
- ☐ 26 weeks P07.25
- ☐ 27 weeks P07.26
- ☐ 28 weeks P07.31
- ☐ 29 weeks P07.32
- ☐ 30 weeks P07.33
- ☐ 31 weeks P07.34
- ☐ 32 weeks P07.35
- ☐ 33 weeks P07.36
- ☐ 34 weeks P07.37
- ☐ 35 weeks P07.38
- ☐ 36 weeks P07.39

Insurance Information

Medicaid ID # _____

HMO Name_____

HMO ID #_____

Pertinent Information

Current weight_____ ☐ kg ☐ lbs

Date recorded_____

Multiple births? ☐ Yes ☐ No
Enter names of Synagis candidates below (submit separate enrollment forms)

Shipment Information

Ship to: ☐ Patient home
☐ Prescriber's office
☐ Other
Address if different from prescriber's
_____
_____

☐ Yes, Americare is to coordinate home health nurse visit for injection. If yes, agency of choice _____

☐ No coordination

PRESCRIPTION INFORMATION *(This is not a valid prescription. Please escribe or fax Official NYS Prescription to us.)*

Medication	Dose/Strength	Directions	Quantity	Refills
☐ Synagis® (palivizumab)	50 and/or 100mg vials	Inject 15mg/kg IM once per month	QS to achieve 15mg/kg/dose	
☐ Epinephrine	1:1000 vial	Inject 0.01mg/kg SQ prn anaphylaxis	1ml	

I have chosen Americare Pharmaceutical Services Inc. NPI 1679678049, and its employees as an Authorized Agent to assist my staff in handling many of the responsibilities associated with fulfilling the medication requirements of my patients, including specialty medications. These responsibilities include but are not limited to, requesting Prior Authorizations for my patients, answering the criteria questions for the coverage determination within the Prior Authorization Request forms, receiving the Prior Authorization determination from PBMs, as well as any other duties or requirements needed to properly perform a Prior Authorization for my patients. As my Authorized Agent, Americare Pharmaceutical Services, Inc. has been provided all of the required information to accurately complete Prior Authorizations.

X _____
Primary care physician signature

X _____
NICU MD