

Physician Request Form for Synagis®



Fax to PerformRx Pharmacy Services at **866-610-2775**

To speak to a representative, call **866-610-2773**.

Form must be completed for processing.

Patient Name: _____

Member ID#: _____

Address: _____

Apt # or Suite #: _____

City: _____ State: _____

Zip Code: _____

Phone #: _____

Birth Date: _____

Actual Gestational Age: _____ Weeks _____ Days	Next Clinic Visit: _____
Chronological Age: _____ Months _____ Weeks	Has Infant been dosed prior to d/c from Nursery? Yes <input type="checkbox"/> No <input type="checkbox"/> If infant was dosed prior to d/c, when: _____
Weight: _____ lbs _____ oz. = _____ Kg Dose: 15 mg /kg x _____ Kg = _____ mg	Check which Months Synagis to be administered: Oct _____, Nov _____, Dec _____, Jan _____, Feb _____, Mar _____

Medical Risk Factors (Check where applicable and provide details as noted. Please attach any needed documentation)

Is the medication being administered as part of a clinical trial? (please check) Yes No

Bronchopulmonary Dysplasia (BPD) aka Chronic Lung Disease (CLD). Please provide information of how it was diagnosed (i.e. x-ray) _____

Medications for BPD/CLD (provide names and dosages for all that apply):

- Diuretic: _____
- Bronchodilator: _____
- Oxygen: prn or daily? _____ # Liters _____
- Other: _____

Hospitalizations for BPD/CLD. List hospital and dates: _____

Congenital abnormality of the airways: Specify: _____

Neuromuscular disease: Specify: _____

Hemodynamically significant congenital heart disease. Diagnosis: _____

Cyanotic? YES _____ NO _____ Congestive Heart Failure? YES _____ NO _____

CHF Medications. List name and dosage: _____

Pulmonary Hypertension? Medications for pulmonary Hypertension? _____

Severe Immunodeficiency? YES _____ NO _____ If, Yes, list Diagnosis: _____

Please only fill out for Gestational Age 32 to less than 35 weeks AND under 3 months of age (provide as much detail as possible)

- Patient attends daycare. Name of daycare: _____ Number of days per week: _____ Number of hours per day: _____
- Siblings. Please list number of siblings and their ages: _____
- Environmental air pollutants: Specific pollutant(s): _____
- Other- List all that you think apply: _____

Any other significant medical information. Describe: _____

Physician Information/Delivery Information

Physician Information Delivery of Medication to Physicians Office – Pharmacy Billing Office Reimbursement Requested – Physician Billing

Administration code _____ Number of units _____

Physician Name (Print/Stamp): _____ NPI # _____

Mailing Address _____ Suite # / Floor: _____ Office Contact: _____

City: _____ State: _____ Zip Code: _____ Fax Number: _____

Physician Signature: _____ Phone Number: _____

For delivery through our preferred specialty pharmacy, please fax or call the prescription to CarePlus Specialty Pharmacy:

Pharmacy Name CarePlus Specialty Pharmacy Phone 800-619-2531 Fax 800-240-6125 Date Medication is required: _____

