MAXOR® Specialty Pharmacy

SYNAGIS®

Patient Referral/Medication Request Form
216 S. Polk Street, Amarillo, TX 79101
Phone: 1-866-629-6779 • Toll Free Fax: 1-866-217-8034

PATIENT INFORMATION

Patient Name ______________________________
Date of Birth: ____________ SSN: ____________ Sex: ☐ Male ☐ Female
Home Address: ____________ City: ____________ State: ______ Zip: ______
Parent/Guardian: ______________________________
Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

INSURANCE INFORMATION

Include copies of the patient's insurance cards and drug benefit cards (front and back)

Primary Insurance: ____________ Phone #: ____________
Policy Number: ____________ Group #: ____________
Card Holder Name & SSN (if not patient) ____________
Secondary Insurance: ____________ Phone #: ____________
Policy Number: ____________ Group #: ____________
Card Holder Name & SSN (if not patient) ____________

CLINICAL INFORMATION

PRIMARY DIAGNOSIS:

Patient's Gestational Age (GA): ____________ Birth Weight: ________kg (lb)
Current Weight: ____________kg (lb) Date Recorded: ____________
Date Recorded: ____________

- ☐ Congenital Heart Disease (745.0-747.9)
- ☐ 29-30 weeks GA (765.25)
- ☐ Chronic Respiratory Disease Arising in the Perinatal Period (CLD) (770.7)
- ☐ 31-32 weeks GA (765.26)
- ☐ ≤24 weeks GA (765.21-765.22)
- ☐ 33-34 weeks GA (765.27)
- ☐ 25-26 weeks GA (765.23)
- ☐ 35-36 weeks GA (765.28)
- ☐ 27-28 weeks GA (765.24)
- ☐ 37 or more weeks GA (765.29)
- ☐ Other Respiratory Conditions of Fetus & Newborn (770.0-770.9)
- ☐ Congenital Anomalies of Respiratory System (748)
- ☐ Other ____________

Secondary diagnosis (if applicable) ____________

MEDICAL CRITERIA

1. Diagnosis of chronic pulmonary disease (CLD/BPD) and less than 24 months of age? ☐ Yes ☐ No
   Is patient receiving medical treatment of (check all that apply & provide last date received):
   ☐ Oxygen Date: ______ ☐ Corticosteroids Date: ______ ☐ Bronchodilator Date: ______
   ☐ Diuretics date: ______
2. Diagnosis of hemodynamically significant congenital heart disease and less than 24 months of age? ☐ Yes ☐ No
   Patient has the following condition: ☐ Diagnosis of moderate-severe pulmonary hypertension
   ☐ Medications for CHD: ____________ Late date received: ______
3. Prematurity: ☐ Gestational age of ≤28 weeks and <12 months of age at the start of RSV season
   ☐ Gestational age of 29-32 weeks & <6 months of age at the start of RSV season
   ☐ Gestational age of 32-35 weeks & <6 months at the start of RSV season

(Most payors require two of the below AAP approved risk factors listed in the left column. Check all that apply):

☐ **School-age siblings**	☐ Birth weight less than 2500g
☐ **Exposure to environmental air pollutants**	☐ Crowded living conditions
☐ **Day Care**	☐ Multiple birth
☐ **Severe neuromuscular disease**	☐ Family history of asthma
☐ **Congenital abnormality of airway**	

Other medical history: ______________________________
____

NICU HISTORY:

Did the patient spend time in the NICU? ☐ Yes ☐ No If yes, please attach the NICU Discharge Summary
Was RSV prophylaxis recommended by the NICU/HOSPITAL physicians for this patient? ☐ Yes ☐ No
Was there a NICU/HOSPITAL dose administered? ☐ Yes Date(s): ______ ☐ No
EXPECTED DATE OF FIRST/NEXT INJECTION: ____________
Injection already given? ☐ Yes Date(s): ______ ☐ No
Deliver product to: ☐ Office ☐ Patient's Home ☐ Clinic
Clinic Location: ____________
Agency Nurse to visit home for injection? ☐ Yes ☐ No
Agency Name: ____________

TAPE PRESCRIPTION HERE PRIOR TO FAXING REFERRAL OR COMPLETE THE FOLLOWING:

RX

☐ **Synagis® (palivizumab)** 50-and/or 100mg vials

Sig: Inject 15mg/kg IM one time per month (for liquid formulation only)

Round to nearest 0.1 mL

Dispense Quantity: QS Refill ______ months

☐ Epinephrine 1:1000 amp. Sig: Inject 0.01 mg/kg as directed

☐ Known Allergies: ____________

☐ Other ____________

Sig: ____________

Anticipated Start Date: ____________ **Today's Date:** ____________

Physician's Signature: ______________________________ **M.D.**

☐ **Dispense as Written** ☐ **Generic Substitution Permitted**

Physician's Name: ____________ **Office Contact:** ____________
Address: ____________ **Phone:** ____________
City/State/ZIP: ____________ **Fax:** ____________
NPI #: ____________ **DEA #:** ____________ **License #:** ____________

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