

FAX COMPLETED FORM TO:

AcariaHealth 877.252.2444

For Questions, Please Call: 877.796.2447

Are you referring this patient from a NICU/HOSPITAL? Y N

PATIENT INFORMATION				PATIENT INSURANCE	
Last Name	First Name	Middle Initial	<input type="checkbox"/> M <input type="checkbox"/> F	Primary Insurance Plan	Phone (back of card)
Street Address		City		Policy ID #	Group #
County	State	ZIP Code		Policy Holder Name / Date of Birth	
Date of Birth	Birth Weight (kg/lb)	Social Security #		Secondary Insurance Plan	Phone (back of card)
Parent/Guardian		Primary Language Spoken		Policy ID #	Group #
Day Telephone (+Area Code)		Cell/Night Telephone (+Area Code)		Policy Holder Name / Date of Birth	Employer

PRIMARY DIAGNOSIS

Patient's Gestational Age (GA) _____ weeks Birth Weight _____ kg lbs.
 Current Weight _____ kg lbs. Date Recorded _____ / _____ / _____

Congenital Heart Disease (Q20.0 - Q28.9) 29-30 weeks GA (P07.32; P07.33)
 Chronic Respiratory Disease Arising in the Perinatal Period (CLD) (P27.0; P27.1; P27.8) 31-32 weeks GA (P07.34; P07.35)
 Less than or equal to 24 weeks GA (P07.2; P07.22; P07.23) 33-34 weeks GA (P07.36; P07.37)
 25-26 weeks GA (P07.24 ; P07.25) 35-36 weeks GA (P07.38 ; P07.39)
 27-28 weeks GA (P07.26 ; P07.31) 37 or more weeks GA _____
 Other Respiratory Conditions of Fetus and Newborn (P27.0; P27.1; P27.8) Congenital Anomalies of Respiratory System (Q30.0)
 Other _____ Secondary Diagnosis (if applicable) _____

MEDICAL CRITERIA

1. Diagnosis of chronic pulmonary disease (CLD/BPD) and less than 24 months of age? <input type="checkbox"/> Yes <input type="checkbox"/> No	Clinically has the following risk factors (check all that apply): <input type="checkbox"/> School-age siblings <input type="checkbox"/> Birth weight less than 2500g <input type="checkbox"/> Exposure to environ. air pollutants <input type="checkbox"/> Crowded living conditions <input type="checkbox"/> Day care <input type="checkbox"/> Day care <input type="checkbox"/> Severe neuromuscular disease (ICD-10 code: _____) <input type="checkbox"/> Family history of asthma <input type="checkbox"/> Congenital abnormality of airway <input type="checkbox"/> Other
2. Diag. of hemodynamically significant congenital heart disease and less than 24 months of age? <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Prematurity: <input type="checkbox"/> Gestational age of less than 28 weeks and less than 12 months of age at the start of RSV season <input type="checkbox"/> Gestational age of 29-32 weeks and less than 6 months of age at the start of RSV season <input type="checkbox"/> Gestational age of 32-35 weeks and less than or equal to 3 months of age at the start of RSV season <input type="checkbox"/> Gestational age of 32-35 weeks and greater than 3 months but less than or equal to 6 months of age at the start of RSV season	
Patient Allergies: <input type="checkbox"/> Other medications patient is currently taking (including OTC medications) with dosage and direction (or fax medication profile):	

NICU HISTORY

Did the patient spend time in the NICU? Yes No If yes, please attach 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

PRESCRIPTION INFORMATION

First/Next Injection Due Date: _____ **Delivery and administration location:** MD Office Patient Home Clinic

Check if AcariaHealth is to coordinate home nursing, please provide: Agency Name _____ Phone #: _____
 Check If home nursing is already established, please provide: Agency Name _____ Phone #: _____

Synagis® (palivizumab) 50 and/or 100 mg vials (Will dispense 50 mg/0.5 ml and/or 100 mg/ml vial(s) based on prescribed dose)
Sig: Inject 15 mg/kg IM every 28 days. (Dose to be calculated at time of injection, based on patient's current weight)
Quantity: QS Refills: _____ Refills through _____
To dispense the prescribed dose required at the time of injection, the patient's weight will be estimated as per standard operating procedure.

Syringes 1 ml 25G 5/8" (to withdraw) Needles (to inject) Gauge: 25 Length: 5/8" Quantity: QS (for both syringes & needles)
 Epinephrine 1:1000 amp (if required for home administration).
Sig: Call 911 & MD then Inject 0.01 mg/kg _____ mg SQ x1, may repeat as needed for anaphylaxis as directed # 3 amps Qty _____ Refills _____
 Other _____ Qty _____ Refills _____

PHYSICIAN INFORMATION

Practice Name	Synagis Contact Name	Prescriber's Name	Specialty
Prescriber's State License #	DEA#	Phone #	Fax #
Medicaid Provider #	NPI#	Address	City / State / ZIP

Prescriber's Signature

Date

Prescriber certifies that this referral form contains an original signature and is signed by the treating physician. IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual named. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document by mistake, then destroy this document. Please direct all verification or notification to AcariaHealth or any of its subsidiaries using the contact information provided on this coversheet.

Synagis® is a registered trademark of MedImmune, Inc.