SYNAGIS®
PALIVIZUMAB

Universal Referral Form

Please complete and sign this form, then send it to SYNAGIS CONNECT by fax at **1-800-201-4938** or by email at **synagisconnect@rxallcare.com**. Alternatively, you may fax it to any appropriate specialty pharmacy. If you have any questions, call SYNAGIS CONNECT at 1-866-285-8419.

○ Preferred Specialty Pharmacy Name:_______________ Fax #:_______________

○ Buy and Bill (Benefits Investigation)

Please fax a copy of insurance and prescription cards (front and back) with this form.

PATIENT INFORMATION

Last Name:_______________ First Name:_______________ Middle Initial:_______________

Date of Birth:_____/_____/_____ Gender: ○ Male ○ Female Birth Weight:_____lb_____oz or_____grams

Current Weight:_____lb _____oz or _____kg on date_____/_____/_____

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name:_______________ Primary Language: _______________

Address:_______________ City/State:_______________ ZIP:_______________

Phone #: Home: _______________ Mobile: _______________ Work:_______________

Email Address: _______________ Preferred Contact Method: ○ Phone ○ Text ○ Email

INSURANCE INFORMATION **(Please provide copies of all insurance and prescription cards [front and back])**

Policyholder Full Name: _______________ Policyholder Date of Birth: _______________

Primary Medical Insurance: _______________

Insurance Phone #:_______________ Employer: _______________

Group #:_______________ Policy #: _______________ ID #: _______________

Secondary Medical Insurance:_______________ Insurance Phone #: _______________

Group #:_______________ Policy #:_______________ ID #:_______________

Pharmacy Benefit:_______________ RxBIN:_______________ RxPCN:_______________

Cardholder Name: _______________

MEDICAL CRITERIA **(Attach required medical documentation)**

○ **Prematurity:** Gestational age _______________ (weeks/days) ICD10:_______________

Bronchopulmonary dysplasia (BPD)/chronic lung disease (CLD)

○ Aged <12 months

○ Aged 12 to <24 months

- ○ Supplemental oxygen (dates): _______________ ○ Chronic corticosteroids (drugs/dates):_______________
- ○ Diuretic therapy (drug/dates):_______________ ○ Bronchodilators (drugs/dates):_______________

Diagnosis:_______________ ICD10: _______________

Hemodynamically significant congenital heart disease

○ Aged <12 months

○ Aged 12 to <24 months

Diagnosis:_______________ ICD10: _______________

Other conditions

Description:_______________

Diagnosis:_______________ ICD10: _______________

CONTINUED ON NEXT PAGE

PATIENT NAME: ________________________ DATE OF BIRTH: ____/____/____ PHONE #: ____________________

PHYSICIAN INFORMATION

Last Name: ______________________ First Name: ______________________

License #: ______________ NPI #: ______________ Medicaid Provider ID: ______________

Practice/Office/Clinic/Institution Name: ______________________

Address: ______________________ City/State: ______________ ZIP: __________

Phone #: ______________ Ext: ______ Fax #: ______________ Office Email: ______________

HCP Office Point of Contact: ______________________

PRESCRIPTION INFORMATION

NICU/Hospital Dose Administered: ◯ Yes ◯ No Date(s): ______________________

Needs by Date: ______________________ Expected Date of First/Next Injection: ______________________

Current Medications: ______________________

Known Allergies: ______________________

Rx SYNAGIS 50-mg and/or 100-mg vials. Please indicate the required number of vial(s) to achieve 15-mg/kg dose.

◯ **SYNAGIS 50 mg:** Inject 15 mg/kg intramuscularly once per month (every 28-30 days) **Quantity**______

REFILLS: (Please enter "0" if no refills remain) _____ (REQUIRED)

DISPENSE AS WRITTEN

SIGN HERE **Prescriber Signature** ____________________ **Date**________

SUBSTITUTION PERMITTED

SIGN HERE **Prescriber Signature** ____________________ **Date**________

◯ **SYNAGIS 100 mg:** Inject 15 mg/kg intramuscularly once per month (every 28-30 days) **Quantity**______

REFILLS: (Please enter "0" if no refills remain) _____ (REQUIRED)

DISPENSE AS WRITTEN

SIGN HERE **Prescriber Signature** ____________________ **Date**________

SUBSTITUTION PERMITTED

SIGN HERE **Prescriber Signature** ____________________ **Date**________

◯ **Epinephrine 1:1000 amp:** Inject 0.01 mg/kg SubQ as directed **Quantity:** 1 ampule. No refills.

DISPENSE AS WRITTEN

SIGN HERE **Prescriber Signature** ______________________________ **Date**______________

SUBSTITUTION PERMITTED

SIGN HERE **Prescriber Signature** ______________________________ **Date**______________

◯ Ancillary supplies and kits provided as needed for administration

DELIVERY INFORMATION

Deliver to: ◯ Office/Clinic ◯ Patient's home ◯ Other______________________

Home Health Services Preferred for Injection Administration? ◯ Yes ◯ Currently receiving ◯ No

Home Health Agency Name: ______________________

Home Health Agency Contact: ______________________ Home Health Agency Phone #: ______________________

PRESCRIBER AUTHORIZATION

I acknowledge that I have obtained the parent's or guardian's authorization to release the information contained in this form and such other information as may be required by Sobi, Inc. and its employees, agents or contractors in connection with SYNAGIS CONNECT to assist the parent or guardian in obtaining coverage for SYNAGIS and/or to assist the parent or guardian in initiating or continuing the patient's SYNAGIS therapy. I certify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge. I have prescribed SYNAGIS based on my judgment of medical necessity and I will be supervising the patient's treatment. I authorize the forwarding of this prescription to the dispensing specialty pharmacy on behalf of myself and the parent or guardian. I understand that neither I nor the parent or guardian may seek reimbursement for any free product received under any program. By signing below, the physician attests that this is his/her legal signature. No stamps.

SIGN HERE **Prescriber Signature** ______________________________ **Date** ______________

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

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