Carepoint™
A Pharmacy That Truly Cares

Synagis (PALIVIZUMAB) Referral Form

P: (855) 237-9112 | F: (855) 237-9113 | www.carepointrx.com

Thank You For Trusting Us With Your Patients Care.

Date Shipment Needed:_____ **Ship To:** ☐Patient ☐Physician ☐Nursing Needed

Agency nurse to visit home for injection? ☐ Yes ☐ No

PATIENT INFORMATION

Patient Name:_____

Address:_____

Address 2:_____

City:_____ St:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Date of Birth: _____/_____/_____ Sex: M_____ F_____

Primary Guardian:_____

Dr. Office Shipping Address:

_____

_____

Insurance Card Holder Name: _____

Rx Ins.: _____ ID#_____ Group#_____ RXBIN:_____

Med Ins.: _____ ID#_____ Group#_____ RXBIN:_____

Secondary Guardian:_____

Patient one of multiple births? Y_____ N_____ *If Yes, is sibling(s) referral being submitted simultaneously? Y_____ N_____*

Sibling Name(s):_____ May Pharmacy Contact Directly?: Y_____ N_____

CLINICAL INFORMATION

PRIMARY DIAGNOSIS

Patient's gestational age (GA)_____ **Birth Weight** _____**kg/lb** **Current Weight:**_____**kg/lb** **Date Current Weight Recorded:**_____ **Diagnosis Code:**_____

MEDICAL CRITERIA: ☐ Medical records included

1.☐ Diagnosis of chronic lung disease or prematurity/bronchopulmonary dysplasia (CLDP/BPD) and ≤24 months of age

Is patient receiving medical treatment of (check all that apply & provide last date received):

☐ Oxygen date:_____ ☐ Corticosteroids date:_____ ☐ Bronchodilator date:_____ ☐ Diuretic date:_____

2.☐ Diagnosis of hemodynamically significant congenital heart disease (CHD) and ≤24 months of age

Patient has the following condition:

☐ Medications for CHD:_____ ☐ Diagnosis of moderate to severe pulmonary hypertension

Last date received:_____ ☐ Cyanotic CHD

3. Check all risk factors that apply:

☐ Young chronological age (≤12 weeks) ☐ Pre-school or school-aged sibling(s) <5 years of age ☐ Daycare attendance; 2 unrelated children for > 4 hours/week

☐ Birth weight <2500g ☐ Severe neuromuscular disease ☐ Multiple Births

☐ Congenital abnormality of airways ☐ Family history of asthma or wheezing ☐ Residency in rural setting

☐ Exposure to environmental tobacco smoke ☐ Exposure to environmental ail pollutants

Other medical history:_____

_____

HOSPITAL HISTORY

Did the patient spend time in the NICU/PICU/special care nursery? ☐ Yes ☐ No ***If yes, please attach the discharge summary***

Was Synagis (palivizumab) administered in the NICU/hospital/other? ☐ Yes ☐ No Date(s):_____

Expected Date of first/next dose:_____ Dose already given? ☐ Yes Date(s)_____ ☐ No

Rx

☐ Synagis (palivizumab) 50mg and/or 100mg vials. Inject 15mg/kg IM one time per month. QS to acheive 15mg/kg dose Refills:_____

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

☐ Known allergies: _____ ☒ Syringes/Needles 25 g , 5/16" or preferred as needed for administration. Qty: _____ Refills:_____

TREATING PHYSICIAN

Provider Name:_____

Phone: _____ Fax:_____

Clinic: _____

Office Contact:_____

NPI #:_____ DEA #:_____

Address:_____

REFERRING PHYSICIAN

Provider Name:_____

Phone: _____ Fax:_____

Clinic: _____

Office Contact:_____

NPI #:_____ DEA #:_____

Address:_____

Original Signature of Presciber Date

Pharmacy can only accept original prescription drug orders from patients. Faxed referrals/prescriptions are accepted from physicians office only

By Signing this form and utilizing our services, you are authorizing Carepoint and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies. This form should not be construed as coding advice. Each practitioner is solely responsible for ensuring the accuracy of the information submitted.