BLUEGRASS PHARMACY | 2015-2016 SYNAGIS™ SEASON RESPIRATORY SYNCYTIAL VIRUS ENROLLMENT FORM

BLUEGRASS Pharmacy
A Member of the Wellpartner Family

FAX FORM TO: 1.866.233.8317 | **PHONE:** 1.855.492.0817 | **EMAIL:** contact@bluegrass-rx.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION

Name:

Address:

City, State, ZIP:

Primary Phone: - - DOB: / /

Alternate Phone: - - Gender:

Email:

Primary Language: Last Four of SSN:

2. PRESCRIBER INFORMATION

Name:

DEA #: NPI #: State Lic. #:

Group or Hospital:

Address:

City, State, Zip:

Phone: - - Fax: - -

Contact Person: Phone: - -

3. INSURANCE INFORMATION

*Fax copy of **prescription** and **insurance cards** with this form, if available (front and back)*

Primary Insurance Company Name:

Primary Cardholder Name:

Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent

Phone: - - Member ID: Group #:

Secondary Insurance Company Name:

Secondary Cardholder Name:

Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent

Phone: - - Member ID: Group #:

4. DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: / / Ship to: ◯ Patient ◯ Office ◯ Other:

ICD-10 Code

- ◯ PØ7.21 <23 weeks of gestation
- ◯ PØ7.22 23 weeks of gestation
- ◯ PØ7.23 24 weeks of gestation
- ◯ PØ7.24 25 weeks of gestation
- ◯ PØ7.25 26 weeks of gestation
- ◯ PØ7.26 27 weeks of gestation
- ◯ PØ7.31 28 weeks of gestation
- ◯ PØ7.32 29 weeks of gestation
- ◯ PØ7.33 30 weeks of gestation
- ◯ PØ7.34 31 weeks of gestation
- ◯ PØ7.35 32 weeks of gestation
- ◯ PØ7.36 33 weeks of gestation
- ◯ PØ7.37 34 weeks of gestation
- ◯ PØ7.38 35 weeks of gestation
- ◯ PØ7.39 36 weeks of gestation
- ◯ 770.7 Chronic respiratory disease arising in the perinatal period (CLD)
- ◯ 748.3 Congenital abnormality of respiratory system
- ◯ Other:

Patient Evaluation

Patient's gestational age: ____ weeks ____ days Birth weight: ____ lb/kg ____ oz Current weight: ____ lb/kg ____ oz

Multiple births? ◯ Yes ◯ No Names of sibling RSV candidates (submit separate enrollment forms):

Chronic lung disease (CLD/BPD) and <24 months chronological age **AND** treated for CLD within 6 months at start of RSV season **AND** (check all that apply): ◯ Continuous oxygen (date: / /) ◯ Diuretics (date: / /) ◯ Corticosteroids (date: / /) ◯ Bronchodilator (date: / /)

Congenital heart disease (CHD) and <24 months chronological age at start of season and hemodynamically significant (check all that apply): ◯ Cyanotic heart disease ◯ Acyanotic heart disease ◯ Moderate/severe pulmonary hypertension ◯ Surgery to correct CHD Date: / / ◯ Medications to control CHD: _____ Start date: / /

◯ Compromised handling of secretions due to significant abnormalities of airway/neuromuscular condition and <12 months at start of RSV season

◯ Prematurity gestational age of ≤ 28 weeks, 6 days and less than 12 months at the start of season

◯ Prematurity gestational age of 29 weeks, 0 days to 31 weeks, 6 days **AND** less than 6 months at the start of season

◯ Prematurity gestational age of 32 weeks, 0 days to 34 weeks, 6 days with the following risk factor(s) **AND** less than 3 months at the start of season:
- ◯ Siblings < 5 years old living in the same household. Name: _____ DOB: / /
- ◯ Childcare attendance with 2 or more unrelated children > 4 hours per week. Daycare name: _____ Start date: / /

NICU history? ◯ Yes ◯ No If yes, NICU name: _____
Was this season's first Synagis dose given in the NICU? ◯ Yes ◯ No If yes, dates: / / *Please include NICU summary.*

Allergies: Other medical history and/or risk factors:

Expected date of first/next injection: / / Injection(s) already given? ◯ Yes ◯ No If yes, date(s): / / , / /

Pharmacy to coordinate home health nurse visit for injection? ◯ Yes ◯ No Agency of choice:

5. PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
◯ Synagis™ and ancillary supplies*	◯ 50 mg vials ◯ 100 mg vials	◯ Inject 15 mg/kg IM once a month. ◯ Other:	◯ QS 90 days ◯ QS 30 days	
◯ Epinephrine and ancillary supplies*	1:1000 amp	◯ Inject 0.01 mg/kg SQ as directed for anaphylaxis. ◯ Other:		
◯				

*Please list necessary ancillary supplies:

◯ Parent or guardian has been counseled on Synagis therapy and Wellpartner may contact parent or guardian

6. PRESCRIBER SIGNATURE

X / /

DISPENSE AS WRITTEN DATE

X / /

PRODUCT SUBSTITUTION PERMITTED DATE