



CVS Caremark Connect:  
Phone: 800-237-2767 Fax: 800-323-2445

## 2009-2010 Synagis® Season Respiratory Syncytial Virus Enrollment Form



**Fax Referral To Caremark Connect:  
800-323-2445**

Date: \_\_\_\_\_  
Needs by Date: \_\_\_\_\_

Ship to:  Patient  Office  Other: \_\_\_\_\_

### PATIENT INFORMATION

*(Complete the following or send patient demographic sheet)*

Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
County: \_\_\_\_\_ City, St., Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Alternate Ph.: \_\_\_\_\_  
SS #: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

### PRESCRIBER INFORMATION

Prescriber's Name: \_\_\_\_\_  
State License #: \_\_\_\_\_ UPIN: \_\_\_\_\_  
DEA #: \_\_\_\_\_ NPI #: \_\_\_\_\_  
Group or Hospital: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

### INSURANCE INFORMATION *(Please copy and attach the front and back of insurance and prescription drug card)*

**Primary Insurance:** Subscriber: \_\_\_\_\_ ID#: \_\_\_\_\_ Name of Insurer: \_\_\_\_\_ Phone: \_\_\_\_\_  
**Secondary Insurance:** Subscriber: \_\_\_\_\_ ID#: \_\_\_\_\_ Name of Insurer: \_\_\_\_\_ Phone: \_\_\_\_\_

### Diagnosis (Required): **ATTACH NICU DISCHARGE SUMMARY**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> < 24 weeks of gestation (765.21)  | <input type="checkbox"/> 29-30 weeks of gestation (765.25) | <input type="checkbox"/> 37 weeks+ of gestation (765.29) | <input type="checkbox"/> Congenital Heart Disease (Specify ICD-9) _____                            |
| <input type="checkbox"/> 24 weeks of gestation (765.22)    | <input type="checkbox"/> 31-32 weeks of gestation (765.26) |  | <input type="checkbox"/> Chronic Respiratory Disease arising in the perinatal period (CLD) (770.7) |
| <input type="checkbox"/> 25-26 weeks of gestation (765.23) | <input type="checkbox"/> 33-34 weeks of gestation (765.27) |  | <input type="checkbox"/> Congenital Abnormality of Respiratory System (748.3-748.4)                |
| <input type="checkbox"/> 27-28 weeks of gestation (765.24) | <input type="checkbox"/> 35-36 weeks of gestation (765.28) |  | <input type="checkbox"/> Other: _____  |

### Patient Evaluation:

- Patient's gestational age (Required): \_\_\_\_\_ weeks \_\_\_\_\_ days • Birth Weight: \_\_\_\_\_ g/kg/lbs • Current Weight: \_\_\_\_\_ g/kg/lbs • Date Recorded: \_\_\_\_\_
- Diagnosis of Chronic Lung Pulmonary Disease\* (CLD/BPD) and less than 24 months at start of RSV Season?  Yes  No ICD-9: \_\_\_\_\_
- \* Chronic Lung Disease is generally defined:
  - For infants <32 weeks: Oxygen requirement at 36 weeks gestation age or at discharge.
  - For infants ≥ 32 weeks: Oxygen requirement at age 28 days or greater or at discharge.
- Treatment for CLD within 6 months of onset of RSV season with:
 

<input type="checkbox"/> Oxygen	Date: _____	<input type="checkbox"/> Corticosteroids	Date: _____
<input type="checkbox"/> Diuretics	Date: _____	<input type="checkbox"/> Bronchodilator	Date: _____
- Diagnosis of hemodynamically significant congenital heart disease and less than 24 months of age?  Yes  No ICD-9: \_\_\_\_\_
- Patient has the following conditions:
 

<input type="checkbox"/> Moderate-Severe Pulmonary Hypertension	<input type="checkbox"/> Cyanotic Heart Disease	ICD-9: _____	Date: _____
<input type="checkbox"/> Acyanotic Heart Disease	<input type="checkbox"/> Medications for CHF (list): _____		Last date received: _____
- Compromised handling of respiratory secretions and less than 12 months at the start of RSV season AND diagnosis of:
 

<input type="checkbox"/> Congenital abnormality of the airway	ICD-9: _____
<input type="checkbox"/> Neuromuscular condition	ICD-9: _____
- Prematurity:
 

<input type="checkbox"/> Gestational age of ≤ 28 weeks, 6 days and less than 12 months at the start of the RSV season
<input type="checkbox"/> Gestational age of 29 weeks, 0 days – 31 weeks, 6 days and less than 6 months at the start of RSV season
<input type="checkbox"/> Gestational age of 32 weeks, 0 days – 34 weeks, 6 days AND less than 3 months at start of RSV season AND has one of the following risk factors:

<input type="checkbox"/> Sibling(s) or other child(ren) < 5 years of age living permanently in the same home.	Name(s): _____
	Date of Birth(s): _____
<input type="checkbox"/> Child care attendance (defined as 2 or more unrelated children > 4 hours per week)	Date started: _____ OR will start: _____ Daycare name: _____
- Multiple births?  Yes  No • Names of sibling RSV candidates (please submit separate enrollment form) \_\_\_\_\_
- NICU History:  Yes  No • If yes, NICU name: \_\_\_\_\_ • Was a NICU dose administered?  Yes  No • If yes, date(s): \_\_\_\_\_ (Please include NICU summary)
- Previous injections?  Yes  No • If yes, dates: \_\_\_\_\_ • Expected date of first/next injection: \_\_\_\_\_
- List Allergies: \_\_\_\_\_
- Other medical history: \_\_\_\_\_

### Injection training/Home Health Coordination\*:

\*Please note, separate authorization required. Call 866-796-0530 for prior authorization of home visit.

• Specialty Pharmacy to coordinate injection training/home health nurse visit as necessary.  Yes  No \*Agency of choice: \_\_\_\_\_

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Synagis® (palivizumab)	<input type="checkbox"/> 50 and/or 100mg vials	<input type="checkbox"/> Inject 15mg/kg IM one time per month <input type="checkbox"/> Other: _____	QS to achieve 15mg/kg dose	
<input type="checkbox"/> Epinephrine (when required for home administration)	1:1000 amp	Inject 0.01 mg/kg subcutaneously as directed for anaphylaxis		

### Ancillary Supplies and Kits Provided As Needed for Administration

Parent/Caregivers have been contacted and we have been granted permission to contact

PRODUCT SUBSTITUTION PERMITTED

(Date)

DISPENSE AS WRITTEN

(Date)

Note: The phone number on your fax-back referral confirmation letter will show the CVS Caremark pharmacy contact information for this patient. Please make note of it.

**IMPORTANT NOTICE:** This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. RSV Synagis 090109