



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

2009-2010 Synagis[®] Season Respiratory Syncytial Virus Enrollment Form

ABSOLUTE TOTAL CARE



**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**

- < 24 weeks of gestation (765.21) 29-30 weeks of gestation (765.25) 37 weeks+ of gestation (765.29) Congenital Heart Disease (Specify ICD-9) _____
- 24 weeks of gestation (765.22) 31-32 weeks of gestation (765.26) Chronic Respiratory Disease arising in the perinatal period (CLD) (770.7)
- 25-26 weeks of gestation (765.23) 33-34 weeks of gestation (765.27) Congenital Abnormality of Respiratory System (748.3-748.4)
- 27-28 weeks of gestation (765.24) 35-36 weeks of gestation (765.28) 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:
 - Oxygen Date: _____ Corticosteroids Date: _____
 - Diuretics Date: _____ 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:
 - Moderate-Severe Pulmonary Hypertension Cyanotic Heart Disease ICD-9: _____ Date: _____
 - Acyanotic Heart Disease 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:
 - Congenital abnormality of the airway ICD-9: _____
 - Neuromuscular condition ICD-9: _____
- Prematurity:
 - Gestational age of ≤ 28 weeks, 6 days and less than 12 months at the start of the RSV season
 - Gestational age of 29 weeks, 0 days – 31 weeks, 6 days and less than 6 months at the start of RSV season
 - 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:
 - Sibling(s) or other child(ren) < 5 years of age living permanently in the same home. Name(s): _____
Date of Birth(s): _____
 - 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 866-522-8555 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