US Bioservices
AmerisourceBergen

Synagis® Referral Form

Phone: (877) 872-4604
Fax: (877) 872-4606

Deliver to: ☐ Patient's Home ☐ Prescriber's Office ☐ Other:________ ☐ Hold shipment until notified by prescriber ☐ Anticipated Start Date:________

1. Patient Information

Patient Name: ________
S.S. #:________ Date of Birth:________
Guardian/Caregiver:________
Patient one of multiple births? ☐ Yes ☐ No
If yes, is the sibling(s) referral being submitted? ☐ Yes ☐ No
Sibling name(s):________

Home Phone:________ Work/Mobile Phone:________
Home Address:________
City:________ State:________ Zip:________
Sex: ☐ Male ☐ Female Height:________ Weight:________ ☐ lbs. ☐ kg.
Primary language: ☐ English ☐ Spanish ☐ Other:________

2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription & medical)

Medical Insurance:________ Phone:________
Subscriber Name:________
Policy #:________ Group #:________

Prescription Card: ________ Phone:________
Policy #:________ BIN/PCN:________
Medicare #:________ Medicaid #:________

3. Prescriber Information

Prescriber Name:________ ☐ MD ☐ DO ☐ NP ☐ PA
Practice Name: ________
Address:________
City: ________ State:________ Zip:________

License #:________ NPI #:________ DEA #:________
Phone:________ Fax:________
Office Contact:________ Phone:________
Collaborating Physician:________

4. Diagnosis & Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

☐ Discharge summary included ☐ Medical records included
☐ Pre-school or school aged sibling(s) ☐ Daycare attendance
Gestational age (GA) at birth:________ weeks ________ days
Current weight:________ Date weight recorded:________
ICD-10 diagnosis codes:________, ________, ________
☐ BPD/CLDP: Diagnosis of bronchopulmonary dysplasia/chronic lung disease of prematurity *(specific diagnosis codes(s):* ________, ________)
Patient recieving medical treatment *(check all that apply and provide last date received)*
☐ Oxygen date:________ ☐ Corticosteroids date:________
☐ Bronchodilators date:________ ☐ Diuretics date:________
Known allergies:________

☐ CHD: Diagnosis of hemodynamically significant congenital heart disease
- ☐ Specific diagnosis code(s):________, ________, ________
- ☐ Cyanotic CHD
- ☐ Patient has the following *(check all that apply)*:
  - ☐ Medications for CHD:________
  - ☐ Moderate to severe pulmonary hypertension
  - ☐ Date CHD medications were last received:________

☐ Congenital abnormality of airways *(specific diagnosis code(s):*________)
☐ Severe neuromuscular disease *(specific diagnosis code(s):*________)
☐ Profoundly immunocompromised *(specific diagnosis code(s):*________)
Additional information:________

5. Prescription Information

Medication	Dose/Strength	Directions	Refills
☐ **SYNAGIS®** (palivizumab)	50 mg/0.5 mL and/or 100 mg/mL vial(s)	• Inject 15 mg/kg IM once per month. QS to achieve 15 mg/kg dose	

Was SYNAGIS® previously administered (NICU/hospital/other location)? ☐ Yes ☐ No Date(s) :________ Expected date of next first dose:________

☐ **Home health agency to administer SYNAGIS® 15 mg/kg IM**
For home health administration *(required)*:
- Adrenaline 1 mg/mL
  Sig: Inject 0.01 mg/kg IM/SC as directed
- Ancillary supplies and kits needed for administration

Home health agency name:________
Home health agency phone number:________
Contact name:________

Patient Support Programs: Please have patient sign and date to enroll in pharmaceutical company assisted patient support program.

Patient Signature ________ Date ____ / ____ / ____

Account Manager

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting. NY prescriptions must be submitted via e-script.)

I authorize US Bioservices Corporation to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature-Substitution Permissible PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. ________ Date ____ / ____ / ____

Prescriber Signature-Dispense as Written PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. ________ Date ____ / ____ / ____