Enroll via phone at: 800.906.7798
Enroll via fax at: 877.381.3806
E-prescribing NCPDP: 3982902
NPI: 1639103823 www.acropharmacy.com

SYNAGIS (RSV) INDEPENDENCE BLUE CROSS ENROLLMENT FORM

Today's Date:___________
Needed By:____________
Last update 9.17.2018

Enroll via phone at: 888.203.7973
Enroll via fax at: 888.203.7980
E-prescribing NCPDP: 1079638
NPI: 1598762015 www.commcarepharmacy.com

Patient Demographics:(Please provide the following or attach demographics sheet)
Patient Name:______________________
Address:______________________
City, State, Zip:______________________
Preferred Phone:______________ Alt. Phone:______________
Last four digits of SS#:____________ Date of Birth:______________
Gender:_Allergies:______________Height:_________Weight:_________

Provider Office: (Please provide as much information as possible)
Prescriber's Name:______________________Group/Hospital: ________
Specialty:______________ License#:______________
Address:______________________
NPI:______________________
City, State, Zip:______________________
Phone:_________Fax:___________ Office Contact___________

Insurance Information: (Please copy and attach the front and back of the patient's primary and/or secondary insurance cards)

Medication Delivery to: (choose one) ☐Patient Address ☐Always to Physician's Office ☐First fill to Physician's Office, refills to Patient Address

Medical Criteria (Please attach clinical documentation for all diagnoses below)

1. **Bronchiolitis RSV Hospitalization?** ❑Yes ❑No
2. **Diagnosis of Chronic Lung Diseases (CLD) of prematurity?** ❑Yes ❑No **ICD-10:** __________
   ❑Oxygen: Concentration: ______________________ Dates: ____________________
   ❑Supporting Clinical Documents are attached for Oxygen Use
   ❑Bronchodilator Dates: ___ /___ /___ ❑Corticosteroids Dates: ___ /___ /___ ❑Diuretics Dates: ___ /___ /___
3. **Diagnosis of Hemodynamically Significant Congenital Heart Disease?** ❑Yes ❑No **ICD-10:** __________
   Please include letter from Cardiologist. Patient has the following conditions:
   ❑Diagnosis of Moderate-Severe Pulmonary Hypertension
   ❑Medications for CHF (list): __________________ Date last received: ___ /___ /___
   Recent Surgical Procedure Requiring Cardiopulmonary Bypass
   ❑Yes ❑No – If yes, an additional post-operative dose of palivizumab may be medically necessary
4. **Diagnosis of Cystic Fibrosis with one of the following risk factors?** ❑Yes ❑No **ICD-10:** __________
   ❑Clinical Evidence of CLD ❑Nutritional Compromise ❑Weight for length less than 10th percentile
   ❑Manifestations of severe lung disease (previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest radiography or chest computed tomography that persist when stable)
5. **Diagnosis of profound immunocompromise?** ❑Yes ❑No Reason: ______________________________ **ICD-10:** __________
6. **Diagnosis of Congenital Abnormalities of the airway and 12 months of age or less?** ❑Yes ❑No **ICD-10:** __________
7. **Neuromuscular condition that compromises handling of respiratory secretions and 12 months of age or less?** ❑Yes ❑No **ICD-10:** __________

Patient's Gestational Age: __ weeks ___days
ICD-10: ___________________
Birth Weight: ______________ g/ kg / lbs
Current Weight: _____________ g/ kg / lbs
Date Recorded: ______________________

Rx
❑SYNAGIS (palivizumab) 50 mg and/or 100 mg Vials
Sig: Inject 15 mg/kg IM One Time per Month
Dispense Quantity: QS
Refills Through: ____ / ____ /____

Expected Date of First/Next Injection:
___ / ____ / ____
Previous Injections? ❑Yes ❑No
Dates: ______________________

NICU History
❑Yes ❑No
NICU Name: ______________________
Please Attach the NICU Discharge Summary
Was there a NICU Dose Administered?
❑Yes ❑No Dates: ____ / ____ /____

Other Rx
❑ ________________________________
❑ ________________________________

❑Parent/Caregiver contact:
____
❑Parent/Caregiver has been contacted, and we have been granted permission to contact.

Unless otherwise noted this prescription authorizes Acro and Commcare to dispense & share information between each other to optimize care delivery. Check here to restrict to ☐Acro ☐Commcare

Physician Signature:______________________________ ☐DAW (Dispense as Written) **Date:**______________________

Patient Support Programs: I authorize **Acro Pharmaceutical Services and Commcare Specialty Pharmacy** to enroll me in company-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to injection training. I further authorize the release to communicate to the corresponding manufacturer the minimum necessary information about my health condition and prescription(s) to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis or other commercial purposes, and provide educational information regarding therapies. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. However, I will not be enrolled in the service program listed above. A copy of this authorization will be utilized with the same effectiveness as an original. Ancillary supplies provided as needed for administration.

***Patient Signature:** (required for participation)______________________________ Date:______________ ☐ Please select if you would like the patient enrolled in a Manufacturer's Assistance Program

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