SYNAGIS REFERRAL FORM

ADVANCED PHARMACY and RESPIRATORY CARE SOLUTIONS

Fax Form to: 949-582-6111

Any questions, call intake: 800-464-7736 ext: 3

Today's date: ____/____/____

Patient Name: ______________________

Address: ______________________ Insurance Company: ______________________

City/State/Zip: ______________________ Group/Policy #: ______________________

Phone (day): ______________________ Insurance Phone #: ______________________

Phone (night): ______________________ Mother's Name: ______________________

Gender: ☐ Male ☐ Female DOB:____/____/____ ☐ English ☐ Spanish ☐ Other __________

Statement of Medical Necessity: **Current Weight (kg):** __________

Gestational Age at Birth (weeks & days): __________ **Date Taken:** __________ **Birth Weight (kg):** __________

Please include current Medical Notes or Discharge Summary for patient.

☐ Prematurity gestational age of **<28 weeks, 6 days**-AND less than **12 months** at the start of season.

☐ **Chronic Lung Disease** (CLD/BPD) of prematurity, during the **1st year** of life. Defined as gestational age less than 32 weeks 0 days and a requirement of more than 21% oxygen for at least the first 28 days of birth.

☐ **Chronic Lung Disease (**CLD/BPD) during the **2nd year** of life defined as above and continue to require medical therapy within 6 months before start of second RSV season.
- ☐ Continuous oxygen/date:
- ☐ Corticosteroids/date:
- ☐ >21% Oxygen for at least 28 days after birth:
- ☐ Diuretics/date:
- ☐ Bronchodilators/date:

(check all that apply)

☐ **Congenital heart disease** (CHD) in **1st year** of life, born within 12 months of the RSV season and hemodynamically significant . **(check all that apply)**
- ☐ Cyanotic heart disease:
- ☐ Acyanotic heart disease:
- ☐ Surgery to correct CHD: Date of Surgery: __________ (Date of Surgery or Date to be done)
- ☐ Moderate/severe pulmonary hypertension:
- ☐ Medication to control CHD: __________ (Please list medication) Start Date: __________

☐ Congenital heart disease (CHD) and **younger than 24 months** who undergoes cardiac transplant, bypass surgery or extracorporeal membrane oxygenation during the RSV season. Date of Surgery: ______________________

☐ Compromised handling of secretions due to significant abnormalities of airways/neuromuscular condition and <12 months at start of RSV season.

☐ Profoundly immune compromised, <24 months during RSV SEASON.

☐ Retinophy of Prematurity, provide notes.

☐ Other: ______________________

☐ School aged siblings Ages: ☐ Day Care Attendance :

PRESCRIPTION:

☐ **Rx: SYNAGIS- 15mg per kg, IM, Q 28-30 days X _____ Months** — **Last Synagis Injection given: ____/____/____**

☐ **Rx: EPINEPHRINE- 1:1000 amp inject 0.01mg/kg SQ, for anaphylaxis.** (for doses to be injected @ the home) **Dispensed 1x with 1st dose.**

NICU History ☐ **Yes** ☐ **No**

Was first dose given in NICU ☐ **Yes** ☐ **No**

Please CHECK one: INJECTION to be given by the: ☐ **HOMEHEALTH CARE NURSE OR** ☐ **MD/CLINIC/OFFICE**

Office Contact & E-mail: ______________________

PRINT Doctor Name: ______________________ Phone # : ______________________

Hospital/Clinic Affiliation: ______________________ Office Fax: ______________________

Doctor's Address: ______________________ City: __________ State/Zip: __________

Doctor's NPI #: ______________________ California License# ______________________

Doctor's Signature: ______________________ **M.D.** DATE:___/___/___

CCS Paneled Specialist Co-Signature (if prescribing MD is not): ______________________

Print CCS MD name: ______________________

Primary Care Physician: (If not same as above)

Physician's Name: ______________________ **Office Contact & E-mail:** ______________________

Hospital/Clinic Affiliation: ______________________ Phone #: ______________________

Address: ______________________ Fax #: ______________________

City/State/Zip: ______________________ License #: __________ NPI #: __________