Physician Request Form for Synagis®
Fax to PerformRx Pharmacy Services at **855-452-9131**
To speak to a representative, call **800-684-5502.**
Form must be completed for processing.

AmeriHealth Caritas Louisiana

Patient Name: _____ Member ID#: _____

Address: _____ Apt # or Suite #: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ _____ Birth Date: _____

Actual Gestational Age: Weeks Days	Next Clinic Visit:
Chronological Age: Months Weeks	Has Infant been dosed prior to d/c from Nursery? Yes ☐ No ☐ If infant was dosed prior to d/c, when:
Weight: _____lbs_____oz. = _____Kg Dose: 15 mg /kg x _____Kg = _____ mg	Check which Months Synagis will be administered: Nov ___, Dec___, Jan___, Feb ___, Mar___

Medical Risk Factors (Check where applicable and provide details as noted. Please attach any needed documentation)

Is the medication being administered as part of a clinical trial? (please check) ☐ Yes ☐ No

☐ Bronchopulmonary Dysplasia (BPD) aka Chronic Lung Disease (CLD). Please provide information of how it was diagnosed (i.e. x-ray)_____

Medications for BPD/CLD (provide names and dosages for all that apply):

- ☐ Diuretic: _____
- ☐ Bronchodilator: _____
- ☐ Oxygen: prn or daily? _____ # Liters_____
- ☐ Other: _____

Hospitalizations for BPD/CLD. List hospital and dates: _____

☐ Congenital abnormality of the airways: Specify: _____

☐ Neuromuscular disease: Specify: _____

☐ Hemodynamically significant congenital heart disease. Diagnosis: _____

Cyanotic? YES_____ NO_____ Congestive Heart Failure? YES_____ NO_____

CHF Medications. List name and dosage: _____

☐ Pulmonary Hypertension? YES_____ NO_____ Medications for pulmonary Hypertension?_____

☐ Severe Immunodeficiency? YES_____ NO_____ If, Yes, list Diagnosis: _____

Please only fill out for Gestational Age 32 to less than 35 weeks AND under 3 months of age (provide as much detail as possible)

- ☐ Patient attends daycare. Name of daycare: _____ Number of days per week: _____ Number of hours per day: _____
- ☐ Other children. Please list number of siblings/other children in the house and their ages: _____
- ☐ Environmental air pollutants: Specific pollutant(s):_____
- ☐ Other- List all that you think apply: _____

☐ Any other significant medical information. Describe: _____

HOW SYNAGIS® IS TO BE ADMINISTERED AND FURNISHED (check applicable box)

☐ Physician Office – Drug Reimbursement and Administration (buy and bill)

☐ Physician Office – Drug Administration Only. Drug supplied by Specialty Pharmacy (drug delivery to Physician Office, Member's Home or Store Pickup)

☐ Pharmacy Pickup – Pharmacy Name: _____ Phone: _____

Physician Signature: _____ Date: _____

If you require assistance arranging drug delivery to your office, complete the following:

Administration code _____ Number of units _____ Date Medication is required _____

Physician Name (Print/Stamp): _____ NPI # _____

Mailing Address _____Suite# / Floor: _____ Office Contact: _____

City: _____ State: _____Zip Code: _____

Phone Number: _____ Fax Number: _____

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