APPLE HEALTH (MEDICAID) MEDICARE ADVANTAGE CASCADE SELECT

Medicaid 1-800-440-1561
Medicare 1-800-942-0247
CHNW Cascade Select 1-866-907-1906

Universal Referral Form

Once completed and signed, fax this form to CHPW at 206-613-8873 and fax it to the specialty pharmacy .

Specialty Pharmacy Name: Accredo Fax #: 877-369-3447

Please fax a copy of insurance and prescription cards (front and back) with this form.

PATIENT INFORMATION

Last Name:________________ First Name:________________ Middle Initial:________

Date of Birth:__________ Sex: ◯ Male ◯ Female Birth Weight:________lb________oz or________grams

Current Weight:__________lb __________oz or __________kg on date______/______/______

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name:________________________ Primary Language:________________

Address:________________________ City/State:________________ ZIP:__________

Home Phone #:____________________ Mobile Phone #:____________________

Email Address:________________________ Preferred Contact Method: ◯ Phone ◯ Text ◯ Email

INSURANCE INFORMATION

Policyholder Full Name:________________________ Policyholder Date of Birth:________________

Primary Medical Insurance:____

Insurance Phone #:________________________ Employer:________________

Group #:________________ Policy #:________________ ID #:________________

Secondary Medical Insurance:________________ Insurance Phone #:________________

Group #:________________ Policy #:________________ ID #:________________

Pharmacy Benefit:________________ RxBIN:________________ RxPCN:________________

Cardholder Name:________________________ Social Security #:________________

MEDICAL CRITERIA (Attach required documentation)

◯ **Prematurity:** Gestational age ____________________(weeks/days)

Bronchopulmonary dysplasia (BPD)/chronic lung disease (CLD)

◯ Aged <12 months

◯ Aged 12 to <24 months

◯ Supplemental oxygen (dates): ________________ ◯ Chronic corticosteroids (drugs/dates):________________

◯ Diuretic therapy (drug/dates): ________________ ◯ Bronchodilators (drugs/dates):________________

Diagnosis:________________________ ICD10:________________________

Hemodynamically significant congenital heart disease

◯ Aged <12 months

◯ Aged 12 to <24 months

Diagnosis:________________________ ICD10:________________________

Other conditions

Description:____

Diagnosis:________________________ ICD10:________________________

CONTINUED ON NEXT PAGE

PHYSICIAN INFORMATION

Prescriber Name: ____________________

License #: ____________ NPI #: ____________ DEA #: ____________

Practice Name: ____________________

Address: ____________ City/State: ____________ ZIP: ____________

Phone #: ____________ Fax #: ____________

SYNAGIS® (palivizumab) Coordinator: ____________ Phone #: ____________

PRESCRIPTION INFORMATION

NICU/Hospital Dose Administered: ○ Yes ○ No Date(s): ____________

Needs by Date: ____________ Expected Date of First/Next Injection: ____________

Current Medications: ____________________

Known Allergies: ____________________

Rx SYNAGIS 50-mg and/or 100-mg vials. Please indicate the required number of vial(s) to achieve 15-mg/kg dose.

○ **SYNAGIS 50 mg:** Inject 15 mg/kg intramuscular once per month (every 28-30 days) **Quantity** ______

REFILLS: (Please enter "0" if no refills remain) ______ (REQUIRED)

SIGN HERE **Prescriber Signature** ____________ **Date** ________

○ **SYNAGIS 100 mg:** Inject 15 mg/kg intramuscular once per month (every 28-30 days) **Quantity** ______

REFILLS: (Please enter "0" if no refills remain) ______ (REQUIRED)

SIGN HERE **Prescriber Signature** ____________ **Date** ________

○ **Epinephrine 1:1000 amp:** Inject 0.01 mg/kg SubQ as directed **Quantity:** 1 ampule. No refills.

SIGN HERE **Prescriber Signature** ____________ **Date** ________

○ Ancillary supplies and kits provided as needed for administration

DELIVERY INFORMATION

○ Buy and Bill

Deliver to: ○ Office/Clinic ○ Patient's home ○ Other ____________

Home Health Services Preferred for Injection Administration? ○ Yes ○ Currently receiving ○ No

Home Health Agency Name: ____________________

Home Health Agency Contact: ____________ Home Health Agency Phone #: ____________

PRESCRIBER AUTHORIZATION

I acknowledge that I have obtained the parent's or guardian's authorization to release the information contained in this form and such other information as may be required by Sobi, Inc. and its employees, agents or contractors in connection with SYNAGIS CONNECT to assist the parent or guardian in obtaining coverage for SYNAGIS and/or to assist the parent or guardian in initiating or continuing the patient's SYNAGIS therapy. I certify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge. I have prescribed SYNAGIS based on my judgment of medical necessity and I will be supervising the patient's treatment. I authorize the forwarding of this prescription to the dispensing specialty pharmacy on behalf of myself and the parent or guardian. I understand that neither I nor the parent or guardian may seek reimbursement for any free product received under any program. By signing below, the physician attests that this is his/her legal signature. No stamps.

SIGN HERE **Prescriber Signature** ____________ **Date** ________

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

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