

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: _____

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

SIGN HERE Prescriber Signature _____ Date _____

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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