



**Therapy Enrollment Form**  
 RESPIRATORY SYNCYTIAL VIRUS (RSV) PROPHYLAXIS  
 FAX COMPLETED FORM TO NUMBER LISTED BELOW.

**1**

**PATIENT INFORMATION**

_____ Last Name	_____ First Name	_____ Date of Birth
_____ Street Address		
_____ City	_____ State	_____ ZIP Code
_____ Primary Guardian		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
_____ Day Telephone (+ Area Code)		_____ Night Telephone (+ Area Code)

**INSURANCE INFORMATION**

Include copies of the patient's insurance cards and drug benefit cards (front and back) to expedite benefit clearance.

_____ Primary Insurance	_____ Secondary Insurance
_____ Cardholder Name & Social Security Number (If Not Patient)	_____ Cardholder Name & Social Security Number (If Not Patient)
_____ Group Number	_____ Group Number
_____ Policy Number	_____ Policy Number
_____ Insurance Telephone Number (+ Area Code)	_____ Insurance Telephone Number (+ Area Code)

**2**

**PHYSICIAN INFORMATION**

_____ Prescriber's Name	_____ Site Name	_____ Office Contact
_____ Address		_____ City/State/ZIP Code
_____ Prescriber's License Number	_____ DEA Number	_____ NPI Number
_____ Telephone Number (+ Area Code)		_____ Fax Number (+ Area Code)
_____ Supervising Physician's Name (If Required for Mid-Level Practitioner)		_____ License Number

**3**

FAX COMPLETED FORM TO:



**Walgreens Specialty Pharmacy**  
**Fax: 1-888-325-6544**  
 Ph: 1-888-347-3416 option 4

**4**

**CLINICAL INFORMATION**

**PRIMARY DIAGNOSIS:**

Patient's Gestational Age (GA): \_\_\_\_\_ wk \_\_\_\_\_ days  
 Birth Weight: \_\_\_\_\_ kg/lb Most Current Weight: \_\_\_\_\_ kg/lb  
 Date Recorded: \_\_\_\_\_  >28 6/7 weeks  32 weeks to 34 6/7 weeks  
 29 weeks to 31 6/7 weeks  => 35 weeks

**MEDICAL CRITERIA:**

- Diagnosis of chronic pulmonary disease (CLD/BPD) and less than 24 months of age?  Yes  No  
 Is patient receiving medical treatment of (check all that apply and provide last date received):  
 Oxygen, Last date received: \_\_\_\_\_  Diuretics, Last date received: \_\_\_\_\_
- Diagnosis of hemodynamically significant congenital heart disease (CHD) and less than 24 months of age?  Yes  No  
 Patient has the following condition:  
 Diagnosis of moderate to severe pulmonary hypertension  
 Medications for CHD: \_\_\_\_\_ Date last received: \_\_\_\_\_
- Prematurity:  
 Gestational age of <28 6/7 weeks and <12 months of age at the start of RSV season  
 Gestational age of 29 to 31 6/7 weeks and <6 months of age at the start of RSV season  
 Gestational age of 32 to 34 6/7 weeks and <3 months of age at the start of RSV season and clinically has the following risk factors (check all that apply): **Note: NHP covers Synagis doses up to 3 months of age.**  
 Siblings under the age of 5, list age of siblings: \_\_\_\_\_  
 Day care

Other medical history: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Expected Date of First/Next Injection: \_\_\_\_\_ Injection already given?  Yes, date(s): \_\_\_\_\_  
**\*\*NHP covers Synagis from November through March for a total of 5 seasonal doses.**  No

Deliver product to:  Office  Patient's Home  Clinic Location: \_\_\_\_\_  
 Agency nurse to visit home for injection?  Yes  No Agency Name: \_\_\_\_\_

**Rx**

**Synagis® (palivizumab)** 50 mg and/or 100 mg vials  
 Sig: Inject 15 mg/kg IM one time per month (for liquid formulation only).  
 Dispense Quantity: QS Refill X: 1 2 3 4 5 months (please circle)  
 Known Allergies: \_\_\_\_\_  
 **Other** \_\_\_\_\_  
 Sig: \_\_\_\_\_

Prescriber's Signature \_\_\_\_\_ Date \_\_\_\_\_

