Referral Line: 840-5600
Fax: 840-5678

SYNAGIS Referral Form
Neighbor Island

Neighbor Islands Toll Free Phone: **(888) 840-8844**
Neighbor Islands Toll Free Fax: **(888) 286-7184**

Patient Name:____________________
Parents' Names:____________________
Address:____________________
Home Phone: ____________________
Work Phone: __________ Cell :__________

Physician Name:____________________
Address: ____________________
NPI #: __ __ __ __ __ __ __ __ __ __
Phone : __________ Fax: __________
After Hours Phone No.:____________________

SSN: __________ DOB: ________ SEX: ☐ M ☐ F
Best way to contact family: ☐ Home ph. ☐ Work ph. ☐ Cell ph.
Emergency Contact:____________________
Relationship:__________ **Phone:**__________

Treatment

Gestational Age at Birth (weeks)__________(765.2___)
Birth Weight (kg)_______Current Weight (kg) _______
Date current weight taken:____________________
To be administered at: ☐ MD Office
Has the pt received a course of Synagis before? ☐Y ☐N
Allergies: ____________________

RX: SYNAGIS 15 mg/kg IM per month during the RSV season.
EPINEPHRINE 1:10,000 (0.1mg/ml) #10ml, Inject 0.01mg/kg (0.1ml/kg) SQ prn anaphylactic reaction.

Medical Necessity Criteria *(Check all that apply.)*

☐ Born prematurely at **≤ 28 weeks gestation**** who are born on or after September 15, 2010.
- ☐ Less than 24 weeks (765.21)
- ☐ 24 completed weeks (765.22)
- ☐ 25-26 completed weeks (765.23)
- ☐ 27-28 completed weeks (765.24)

☐ Born between **29-32 weeks gestation**** who are born on or after March 15, 2011.
- ☐ 29-30 completed weeks (765.25)
- ☐ 31-32 completed weeks (765.26)

☐ Born between **33 and 35 weeks gestation**** who are born on or after 6/15/11 requiring significant respiratory support in the neonatal period (positive pressure support).
- ☐ 33-34 completed weeks (765.27)
- ☐ 35-36 completed weeks (765.28)

and have one or more additional risk factors:
- ☐ Child care attendance
- ☐ School-aged siblings
- ☐ Congenital abnormalities of the airways
- ☐ Severe neuromuscular disease

****Premature infants: Documentation of gestational age criteria is required. (e.g. hospital discharge summary, findings to support gestational age)*

☐Other:____________________(ICD-9:_________)

☐ < 2 yrs of age (born on or after September 15, 2009) with **Chronic Lung Disease of the Newborn (770.7)***, requiring ongoing, significant treatments after March 15, 2011.
- ☐ O_2 dependent
- ☐ Recent O_2 use (after 3/15/10)
- ☐ Systemic steroids
- ☐ Inhaled steroids
- ☐ Inhaled bronchodilators
- ☐ Recent hospitalization:________(date)________(reason)

☐ < 2 yrs of age (born on or after September 15, 2009) with hemodynamically significant **Congenital Heart Disease*** requiring medical management after March 15, 2011, such as
- ☐ Congestive Heart Failure on medication (428.9)
- ☐ Moderate to Severe Pulmonary Hypertension (747.83)
- ☐ Cyanotic Heart Disease (770.83)
- ☐ Other:____________________(ICD-9:_______)

(For HMSA patients only, "the following groups of infants are NOT at increased risk from RSV and generally should not receive immunoprophylaxis:" [1]**hemodynamically insignificant heart disease** (e.g. secundum ASD, small VSD, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, PDA), [2]**heart lesions adequately corrected by surgery, or** [3]**mild cardiomyopathy not receiving medical therapy.)**

CLD & CHD: Documentation of medical management is required. (e.g. hospital discharge summary, H&P **if recent, and most recent specialist consult notes, and complete list of medications)*

I certify this patient meets Guidelines for Prophylaxis for RSV Infections in High Risk Infants in Hawaii as developed by the Consensus Committee.

Physician's Signature:____________________ **Date:__________**

Insurance

Primary Insurance:____________________
Address:__________ Ph#:__________
Membership #__________ Group: __________

Secondary Insurance:____________________
Address:__________ Ph#:__________
Membership #: __________ Group:__________

Subscriber/Relationship:______________________________	Subscriber/Relationship:___________________________

Patient Name:________________________________ DOB:_______________

Pharmacare Office Use Only

Primary Insurance:___________________________________	Secondary Insurance:________________________________
Effective Date:____________________Verified by:_________	Effective Date:______________ Verified by:_________
Ded:______________%Cov:_____________SL:___________	Ded:____________%Cov:__________SL:___________
Ded Met:___________Co-pay:____________SL Met:_______	Ded Met:________Co-pay:_________SL Met:_______
TPL:_______________________Life Max:_________________	TPL:_______________Life Max:___________________
Pat. Notified:________________Auth Req?: ☐ Y ☐ N	Pat. Notified:_____________Auth Req?: ☐ Y ☐ N
Accepted OOP? ☐ Y ☐ N ☐ NA	Accepted OOP? ☐ Y ☐ N ☐ NA