



Referral Line: 840-5600
Fax: 840-5678

SYNAGIS Referral Form

Neighbor Islands Toll Free Phone: (888) 840-8844

Neighbor Islands

Neighbor Islands Toll Free Fax: (888) 286-7184

Patient Name: _____	Physician Name: _____
Parents' Names: _____	Address: _____
Address: _____	NPI #: _____
Home Phone: _____	Phone: _____ Fax: _____
Work Phone: _____ Cell: _____	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) To be administered at MD Office
 Birth Weight (kg) _____ Current Weight (kg) _____ Has the pt received a course of Synagis before? Y N
 Date current weight taken: _____ 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.)

<input type="checkbox"/> Born prematurely at ≤ 28 weeks gestation** who are born on or after September 15, 2007. <input type="checkbox"/> Less than 24 weeks (765.21) <input type="checkbox"/> 24 completed weeks (765.22) <input type="checkbox"/> 25-26 completed weeks (765.23) <input type="checkbox"/> 27-28 completed weeks (765.24) <input type="checkbox"/> Born between 29-32 weeks gestation** who are born on or after March 15, 2008. <input type="checkbox"/> 29-30 completed weeks (765.25) <input type="checkbox"/> 31-32 completed weeks (765.26) <input type="checkbox"/> Born between 33 and 35 weeks gestation** who are born on or after 3/15/08 requiring significant respiratory support in the neonatal period (positive pressure support). <input type="checkbox"/> 33-34 completed weeks (765.27) <input type="checkbox"/> 35-36 completed weeks (765.28) and have one or more additional risk factors: <input type="checkbox"/> Child care attendance <input type="checkbox"/> School-aged siblings <input type="checkbox"/> Congenital abnormalities of the airways <input type="checkbox"/> Severe neuromuscular disease **Premature infants: Documentation of gestational age criteria is required. (e.g. hospital discharge summary, findings to support gestational age) <input type="checkbox"/> Other: _____ (ICD-9: _____)	<input type="checkbox"/> < 2 yrs of age (born on or after September 15, 2006) with Chronic Lung Disease of the Newborn (770.7)* , requiring ongoing, significant treatments after March 15, 2007. <input type="checkbox"/> O ₂ dependent <input type="checkbox"/> Recent O ₂ use (after 3/15/06) <input type="checkbox"/> Systemic steroids <input type="checkbox"/> Inhaled steroids <input type="checkbox"/> Inhaled bronchodilators <input type="checkbox"/> Recent hospitalization: _____ (date) _____ (reason) <input type="checkbox"/> < 2 yrs of age (born on or after September 15, 2006) with hemodynamically significant Congenital Heart Disease* requiring medical management after March 15, 2008, such as <input type="checkbox"/> Congestive Heart Failure on medication (428.9) <input type="checkbox"/> Moderate to Severe Pulmonary Hypertension (747.83) <input type="checkbox"/> Cyanotic Heart Disease (770.83) <input type="checkbox"/> 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:" ¹hemodynamically insignificant heart disease (e.g. secundum ASD, small VSD, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, PDA), ²heart lesions adequately corrected by surgery, or ³mild 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)
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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: _____ Subscriber/Relationship: _____	Secondary Insurance: _____ Address: _____ Ph#: _____ Membership #: _____ Group: _____ Subscriber/Relationship: _____
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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