Apollo Specialty Pharmacy

RSV REFERRAL FORM

Phone: 973-350-6155 Fax: 973-556-1560

Patient Information

Patient Name: _____ DOB: _____

Sex: ☐ Male ☐ Female SS #: _____

Primary Language: _____

Address: _____

Apt/Suite #: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Alternate Phone: _____

Caregiver Name: _____ Relation: _____

Insurance Plan: _____ Plan ID#: _____

Please fax a copy of front and back of insurance card(s).

Prescriber + Shipping Information

Physician's Name: _____

DEA #: _____ NPI #: _____ License #: _____

Address: _____

Apt/Suite #: _____ City: _____ State: _____ Zip: _____

Contact: _____

Phone: _____ Fax: _____

Alternate: _____ Email: _____

Ship to: ☐ Patient ☐ Physician ☐ Clinic Address: _____

Clinical Information (please fax all pertinent clinical and lab information)

ICD-10/Diagnosis Code:

- ☐ Q20.0-Q26.4 (Congenital Heart Disease)
- ☐ Q30.0-Q34.9 (Congenital Anomalies of the Respiratory System)
- ☐ P27.1-P27.9 (Chronic Lung Disease of Prematurity)
- ☐ P22.1-P28.9 (Respiratory Conditions of Fetus & Newborn)
- ☐ P07.21-P07.23 (≤24 completed weeks of gestation)
- ☐ P07.24-P07.25 (25-26 completed weeks of gestation)
- ☐ P07.26-P07.31 (27-28 completed weeks of gestation)
- ☐ P07.32-P07.38 (29.35 completed weeks of gestation)

Other (please specify): _____

Secondary diagnosis, if applicable: _____

Gestational Age: _____ Birth Weight: _____ ☐ kg ☐ lbs

Current Weight: _____ ☐ kg ☐ lbs Date Recorded: _____

Allergies: _____

Did the patient spend time in the NICU/PICU/special care nursery? ☐ Yes ☐ No

Discharge date (provide discharge notes): _____

Has Synagis already been administered? ☐ Yes ☐ No

If yes, how many doses: _____ Date(s): _____

Expected date of next/first dose: _____ Agency nurse to visit home for administration? ☐ Yes ☐ No

Agency Name: _____

Medical Criteria for Determination of High-Risk Indication:

- ☐ Infant born before 29 weeks, 0 days gestation that is < 12 months of age at the start of the RSV season
- ☐ Chronic lung disease (CLD) of prematurity (gestational age < 32 weeks, 0 days and a requirement for > 21% oxygen for at least the first 28 days after birth)
  - ☐ First season prophylaxis
  - ☐ Second season prophylaxis; please indicate which treatment(s) & date(s) the patient has received during the 6-month period before the start of the start of the second RSV season
    - ☐ Oxygen: _____ ☐ Bronchodilator: _____
    - ☐ Corticosteroids: _____ ☐ Diuretics: _____
- ☐ Hemodynamically significant CHD in child ≤12 months of age
  - ☐ Acyanotic heart disease, receiving medication to treat CHF, and will require cardiac surgical procedures

    Please list all medication that patient is receiving for treatment of this condition: _____

    _____ Last date received: _____
  - ☐ Moderate to severe pulmonary hypertension
  - ☐ Cyanotic heart defect *(pediatric cardiology consult required)*

Other Relevant Information for Consideration:

- ☐ Diagnosis of Down syndrome with qualifying heart disease, CLD, airway clearance issues, or prematurity (<29 weeks, 0 days gestation)
- ☐ <12 months with neuromuscular disease or congenital anomaly impairing airway secretion clearing
- ☐ <12 months with CF and clinical evidence of CLD and/or nutritional compromise
- ☐ <24 months and undergoing cardiac transplantation during RSV season
- ☐ <24 months and profoundly immunocompromised during RSV season
- ☐ <24 months with CF and manifestations of severe lung disease (previous hospitalization for pulmonary exacerbation in first year of life or abnormalities on chest radiography or chest computed tomography that persist when stable) or weight-for-length less than the 10th percentile
- ☐ Other (please specify): _____

Prescription

- ☐ **Synagis (palivizumab)** 50 mg and/or 100 mg vials
  Inject 15 mg/kg intramuscularly once monthly
  Qty: ☐ Sufficient to achieve 15 mg/kg ☐ Other: _____ Refills: ☐ 1 ☐ 2 ☐ 3 ☐ 4
- ☐ **Epinephrine** 1:1000 ampule
  iNEJCT 0.01 mg/kg subcutaneously as directed
  Qty: ☐ Sufficient to achieve 0.01 mg/kg ☐ Other: _____

Prescriber's Signature: _____ Date: _____

I authorize Apollo pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.