

# Physician Request Form for Synagis®

Fax to AmeriHealth Mercy Pharmacy Services at **888-981-5202**, or to speak to a representative call **866-610-2774**. Form must be completed for processing.



Patient Name: \_\_\_\_\_

AmeriHealth Mercy ID#: \_\_\_\_\_

Address: \_\_\_\_\_

Apt # or Suite #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Actual Gestational Age: _____ Weeks _____ Days	Next Clinic Visit: _____
Chronological Age: _____ Months _____ Weeks	Has Infant been dosed prior to d/c from Nursery? Yes <input type="checkbox"/> No <input type="checkbox"/> If infant was dosed prior to d/c, when: _____
Weight: _____ lbs _____ oz. = _____ Kg Dose: 15 mg /kg x _____ Kg = _____ mg	Check which Months Synagis to be administered: Nov _____, Dec _____, Jan _____ Feb _____, Mar _____

### **Medical Risk Factors (Check where applicable and provide details as noted. Please attach any needed documentation)**

- Bronchopulmonary Dysplasia (BPD) aka Chronic Lung Disease (CLD). Please provide information of how it was diagnosed (i.e. x-ray) \_\_\_\_\_

Medications for BPD/CLD (provide names and dosages for all that apply):

- Diuretic: \_\_\_\_\_
- Bronchodilator: \_\_\_\_\_
- Oxygen: prn or daily? \_\_\_\_\_ # Liters \_\_\_\_\_
- Other: \_\_\_\_\_

Hospitalizations for BPD/CLD. List hospital and dates: \_\_\_\_\_

- Congenital abnormality of the airways: Specify: \_\_\_\_\_

- Neuromuscular disease: Specify: \_\_\_\_\_

- Hemodynamically significant congenital heart disease. Diagnosis: \_\_\_\_\_

Cyanotic? YES \_\_\_\_\_ NO \_\_\_\_\_ Congestive Heart Failure YES \_\_\_\_\_ NO \_\_\_\_\_

CHF Medications. List name and dosage: \_\_\_\_\_

- Pulmonary Hypertension? Medications for pulmonary hypertension? \_\_\_\_\_

- Severe Immunodeficiency? YES \_\_\_\_\_ NO \_\_\_\_\_ If, Yes, list Diagnosis: \_\_\_\_\_

### **Please only fill out for Gestational Age 32 to less than 35 weeks AND under 3 months of age (provide as much detail as possible)**

- Patient attends daycare. Name of daycare: \_\_\_\_\_ Number of days per week: \_\_\_\_\_ Number of hours per day: \_\_\_\_\_
- Siblings. Please list number of siblings and their ages: \_\_\_\_\_
- Other- List all that you think apply: \_\_\_\_\_

- Any other significant medical information. List diagnosis, medications, and any hospitalizations. \_\_\_\_\_

### Physician Information/Delivery Information

Physician Name (Print/Stamp): \_\_\_\_\_

NPI # \_\_\_\_\_

Mailing Address \_\_\_\_\_

Office Contact: \_\_\_\_\_

Suite # / Floor: \_\_\_\_\_

Fax Number: \_\_\_\_\_

City: \_\_\_\_\_

Phone Number: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date Medication required: \_\_\_\_\_

