2014-2015 SYNAGIS REFERRAL FORM

Telephone: 614-355-1100 Fax: 614-355-1111

NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.™

Section 1: Patient Information

Patient name (Last, First): _____ MRN_____ Sex (circle one) M / F

DOB: _____ SSN: _____ Parent name(s) _____

Address: _____ City: _____ State: _____ Zip code: _____

Primary phone: _____ Secondary phone: _____ County: _____

Does patient have sibling referral being submitted simultaneously ☐ Yes ☐ No Sibling name(s) _____

Section 2: Health Insurance Information

☐ No Insurance ☐ Completed ODJFS prior authorization form attached

Primary Insurance: _____ Secondary Insurance: _____

Policy ID Number: _____ Policy ID Number: _____

Group Number: _____ Group Number: _____

Subscriber Name: _____ Subscriber Name: _____

Section 3: Statement of Medical Necessity / Diagnosis Information

Patient's gestational age at birth: _____ Current weight: _____kg Date current weight recorded: _____

Diagnosis and Patient History (check all that apply)

☐ **Gestational age of ≤ 28 weeks & < 12 months of age at start of RSV season (born on or after 11/1/13)**

☐ **Chronic lung disease of prematurity (CLDP)- ICD-9 code:** _____

a. Patient's gestational age is ≤ 31 weeks and 6 days? ☐ Yes ☐ No
b. Patient required > 21% oxygen for at least the first 28 days after birth? ☐ Yes ☐ No
c. Patient is receiving medical treatment? (check all that apply below and provide dates) ☐ Yes ☐ No
   - ☐ Oxygen (dates _____) ☐ Corticosteroids (dates_____)
   - ☐ Diuretics (dates _____) ☐ Bronchodilator (dates_____)

☐ **Hemodynamically significant congenital heart disease (CHD)- ICD-9 code:** _____

- ☐ Severe pulmonary hypertension
- ☐ Cyanotic heart defects and consultation with cardiologist
- ☐ Acyanotic heart disease and receiving medication to control CHF and will require cardiac surgical procedure

☐ **Other- ICD-9 code:** _____

- ☐ Neuromuscular disorder or congenital anomaly that impairs the ability to clear secretions from the upper airway because of ineffective cough
- ☐ Immunocompromised due to chemotherapy or other conditions
- ☐ Cystic Fibrosis with clinical evidence of CLD and/or nutritional compromise

Section 4: Ordering Information (must be signed by physician only)

Was 1st dose of season received in hospital/NICU/other location? Y / N If so, date(s) received: _____

Pharmacy Order:

☐ Synagis (palivizumab) 15mg/kg IM every 28-31 days through 4/30/15 (unless insurance dictates otherwise)
☐ Epinephrine 1:1000 (1 mg/ml) ampule Disp #1. Sig: Inject 0.01 mg/kg IM/SC prn anaphylaxis
(Respectfully requested for all Synagis patients)
☐ No Known allergies **or** List allergies: _____

Nursing Order: Homecare to administer Synagis dose of 15mg/kg IM every 28-31 days & weight to be determined at time of visit
☐ Date of 1st injection to be given between _____and_____ or □ ASAP
☐ If 1st injection given inpatient or in another setting, subsequent injection to be given every 28-31 days of previous injection date x4-6 months
☐ No nursing required

Physician name: _____ **Physician signature:** _____ **Date:** _____

Medicaid ID #: _____ License #: _____ DEA #: _____ NPI #: _____

Office Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____ Office Contact: _____