Physician Request Form for Synagis®

Fax to Pharmacy Services at **855-811-9332**, or to speak to a Representative, call **888-602-3741**. *Form must be completed for processing.*

AmeriHealth Caritas District of Columbia

Patient Name: _____ Patient 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 ☐ No ☐ 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: _____

☐ Children. Please list number of siblings/other children in the house 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: _____

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