University Specialty Pharmacy
3328 Garfield Ave.
Commerce, Ca 90040
P: 323.201.4488
F: 866.728.4810

Name of Case Manager Completing Form: ______________________

Contact Number: (   ) ______________

Contact E-mail: ______________

Patient Information

Patient Last Name ______________________

First Name ______________ M.I. ______

Parent Name (s) ______________________

Street Address ______________________

City ______________ State ____ ZIP ______

Phone (   ) __________ Alt. Contact Phone (   ) __________

Date of Birth __________ M or F ________

MR# __________ Language ______________

Health Insurance Information

PLEASE SEND A LEGIBLE COPY OF ALL INSURANCE CARDS (if avail)

Primary Insurance ______________________

Plan Name ______________ Phone (   ) ________

Subscriber's Name ______________ Policy ID Number ________

Group Number ______________

Subscriber's DOB ________ Subscriber's Employer ________

Secondary Insurance ______________________

Plan Name ______________ Phone (   ) ________

Policy ID Number ______________ Group Number ________

Referring Physician Information

Physician Name ______________________

Practice Name ______________________

Practice Address ______________________

City ______________ State ____ ZIP ______

Phone Number (   ) __________ Fax Number (   ) __________

Synagis Coordinator (Contact) ______________________

DEA Number ______________

Provider Number ______________ NPI Number ______________

Email Address ______________________

Primary Care Physician (PCP) Information

Physician Name ______________________

Address ______________________

City ______________ State ____ ZIP ______

Phone Number (   ) __________ Fax Number (   ) __________

Clinical Information

PRIMARY DIAGNOSIS

PATIENTS GESTATIONAL AGE (GA) → ________ wks Birth Weight ________ kg/lbs

Current Weight ____________ kg/lbs Date Recorded ____________

Current Height ____________ in/cm

- ❑ Other Respiratory Conditions of Fetus and Newborn (770.0-770.9)
- ❑ Congenital Anomalies of Respiratory System (748)
- ❑ Other ______________________

MEDICAL CRITERIA

1. ❑ CLD/BPD and less than **48** months of age? ❑Yes ❑No
   - ❑ Oxygen Date ____________ ❑ Corticosteroids Date ____________
   - ❑ Bronchodilators Date ________ ❑ Diuretics Date ____________
   - ❑ Other ______________________
2. Congenital heart disease and less than **48** months of age? ❑Yes ❑No
   - ❑ Diagnosis ______________________
   - ❑ Medications for CHD ______________________
   - Last Date Received ______________
3. Other ______________________

Risk factors (check all that apply):

- ❑ Child care attendance
- ❑ Children in the home who attend school or preschool
- ❑ Environmental air pollutants, including second hand tobacco smoke
- ❑ Congenital abnormalities of the airways
- ❑ Severe neuromuscular disease

Additional risk factors (check all that apply):

- ❑ Low birth weight ❑ Multiple Birth
- ❑ Crowded living conditions ❑ Family History of Asthma
- ❑ Other Medical History: ______________________

Last Injection __________ **Start Date** (if not immediately) ______________

Prescribing Information

Ancillary Medication (if any): ______________ **Known Allergies:** ______________

Synagis® (palivizumab)
Sig: Inject 15 mg/kg IM Q 28-30 days X ________ months

- ☐ **by home health nurse**
- ☐ **at MD office**

Prescriber's Signature: ______________________ **DATE:** ________