# Respiratory Syncytial Virus (RSV) Enrollment Form 2018-2019

ENVISIONSPECIALTY

## 1. PHARMACY INFORMATION

**EnvisionSpecialty Pharmacy**
Phone: **877.437.9013**
Fax: **877.309.0687**

## 2. PATIENT INFORMATION (Please print or type clearly)

Name____________________ Today's Date ____________
Street Address ____________________
City____________ State________ Zip Code __________
Phone Numbers (Include Area Code): Day ____________
Night____________ Cell Phone ____________
Date of Birth____________ ❑ Male ❑ Female
Allergies ____________________
Primary Caregiver____________ Phone____________
Emergency Contact ____________ Phone____________

**INSURANCE INFORMATION (Include copies of insurance card - front and back):**
Primary Insurance ____________ Phone ____________
Name of Cardholder ____________________
ID #____________ Group # ____________

**DELIVERY INSTRUCTIONS:**
❑ Physician ❑ Other ____________________
Address ____________________
City____________ State____________ Zip Code ____________

## 3. PRESCRIBER INFORMATION *Indicates Required Field

Prescriber (First & Last)* ____________________
NPI #* ____________ DEA #____________
Facility Name ____________________
Street Address* ____________________
City*____________ State*____________ Zip Code* ____________
Phone #*____________ Fax # ____________
Form Submitted By ____________________
CONTACT:
Healthcare Professional____________ Phone #____________

## 4. CLINICAL INFORMATION & MEDICAL ASSESSMENT

Patient's Gestational Age: weeks_______ days______ Birth Weight_________ g/kg/lbs
Current Weight ____________ g/kg/lbs Date Recorded: ____________

***Please document all diagnoses and provide the specific ICD-10 code for each.***

1. Prematurity: Infants less than 12 months of age at the start of RSV season and who were born at or before 28 weeks, 6 days gestation.
   ❑ ICD-10: ____________
2. Diagnosis of chronic lung disease (CLD) and less than 12 months of age?
   ❑ Yes* ❑ No ICD-10: ____________
   ❑ Yes ❑ No Gestational Age ≤31 weeks, 6 days ❑ ICD10: ____________
   ❑ Yes* ❑ No Patient required >21% oxygen for at least the first 28 days after birth

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## CLINICAL INFORMATION & MEDICAL ASSESSMENT (CONT'D)

❑ Yes* ❑ No Patient is 12-24 months of age, meets all CLD requirements above and continues to require medical support for CLD within 6 months of the start of RSV season (check all that apply and provide last date received):
❑ Oxygen (Date): ____________ ❑ Corticosteroids (Date): ____________
❑ Diuretics (Date):____________ ❑ Bronchodilators (Date):____________

3. Diagnosis of hemodynamically significant congenital heart disease and less than 24 months of age? ❑ Yes* ❑ No
   Patient has the following condition(s):
   ❑ Diagnosis of moderate-severe pulmonary hypertension ICD-10: ________
   ❑ Cyanotic heart disease (in consultation with a pediatric cardiologist) ICD-10: ________
   ❑ Acyanotic heart disease (receiving medication to control CHF& will require cardiac surgical procedures) ICD-10: ____________
   ❑ Medications to control CHF: ____________________
   Last date received: ____________
4. Patient is younger than 24 months of age and has undergone cardiac transplantation during the RSV season. ❑ Yes* ❑ No
   Date of Transplant: ____________
5. Neuromuscular Disease/Congenital Airway Abnormality and less than 12 months of age: ❑ Yes* ❑ No
   ❑ Severe neuromuscular disease ICD-10: ____________
   ❑ Congenital or other pulmonary abnormality ICD-10: ____________
6. Profoundly Immunocompromised or receiving chemotherapy during RSV season and less than 24 months of age ❑ Yes* ❑ No
   ICD-10: ____________ Drug Regimen: ____________
7. Patient has a diagnosis of Cystic Fibrosis as well as:
   ❑ Clinical evidence of CLD (under 12 months of age)*
   ❑ Nutritional compromise (under 12 months of age)*
   ❑ Manifestations of severe lung disease (12-24 months of age)*
   (Previous hospitalization for pulmonary exacerbation in 1st year of life or abnormalities on chest radiography or chest computed tomography that persist when stable.)
   ❑ Weight for length less than 10th percentile (12-24 months of age)*
8. Other risk factors: ____________________

## 5. NICU HISTORY:

Did the patient spend time in the NICU? ❑ Yes ❑ No
If yes, please attach the NICU Discharge Summary
Was there a NICU/HOSPITAL RSV dose administered?
❑ Yes – Date(s): ____________ ❑ No
Agency nurse to visit home for injection? ❑ Yes ❑ No
Agency Name: ____________________

***PLEASE PROVIDE CLINICAL DOCUMENTATION WHERE REQUESTED**

## RX

❑ Synagis® (palivizumab): Combination of 50- and/or 100-mg vials
Sig: Inject 15 mg/kg IM one time per month
Dispense Quantity: QS Refill x ________months

❑ Other / Epinephrine: ____________________

**EXPECTED DATE OF FIRST/NEXT INJECTION:**____________
Previous injection(s) given? ❑ Yes ❑ No
Please list all previous injection dates: ____________

Prescriber's Signature:____________________
Date ____________

I authorize EnvisionSpecialty Pharmacy and its representatives to act as my agent to initiate and execute the insurance prior authorization process and, in doing so, to release clinical information via phone or fax to the appropriate PBM.