CenterWell Specialty Pharmacy

Fax: 877-405-7940
Phone: 800-486-2668

CenterWell Specialty Pharmacy™

Monday – Friday, 8 a.m. – 11 p.m., and
Saturday, 8 a.m. – 6:30 p.m., Eastern time

Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

Synagis® Prescription Form

Patient information

Patient: _____ ❒ Female ❒ Male DOB: _____ Height: _____ Weight: _____ ❒ lb ❒ kg Date: _____

Address: _____ City: _____ State: _____ ZIP code: _____

Home phone #: _____ Cell phone #: _____ Caregiver: _____ Caregiver phone #: _____

Other medical conditions: _____ Allergies: ❒ No ❒ Yes: _____

Insurance plan: _____ Plan ID #: _____ BIN: _____ PCN: _____ Group #: _____

*Please send a copy of the patient's prescription insurance card if available.

Clinical information

Diagnosis(es):

❒ ≤ 28 completed weeks of gestation (P07.30 - 7.31)
❒ 29 completed weeks of gestation (P07.32)
❒ 30 completed weeks of gestation (P07.33)
❒ 31 completed weeks of gestation (P07.34)
❒ 32 completed weeks of gestation (P07.35)
❒ 33 completed weeks of gestation (P07.36)
❒ 34 completed weeks of gestation (P07.37)
❒ 35 completed weeks of gestation (P07.38)
❒ Congenital heart disease (ICD-10): _____
❒ Severe chronic lung disease (CLD)(ICD-10): _____
❒ Cystic fibrosis (ICD-10): _____
❒ Neuromuscular disease (ICD-10): _____
❒ Profoundly immunocompromised (ICD-10): _____
❒ Congenital anomalies of the airway (ICD-10): _____

Additional information

Synagis® dose(s) already administered? ❒ No ❒ Yes
Date(s): _____
Gestational age (GA) at birth: _____ Multiple births: ❒ No ❒ Yes
Current weight: _____ kg _____ lbs-oz Date weight recorded: _____
Clinical conditions:
❒ < GA 28 weeks, six days **and** < 12 months at start of season
❒ Chronic lung disease **and** < 12 months of age with GA < 32 weeks **and** required > 21% O_2 for at least first 28 days after birth
❒ Chronic lung disease **and** 12–24 months of age with GA < 32 weeks **and** has required any of the following therapies within the past six months:
  ❒ Oxygen date: _____ ❒ Corticosteroids date: _____
  ❒ Bronchodilators date: _____ ❒ Diuretics date: _____
❒ Hemodynamically significant congenital heart disease **and** < 12 months of age at start of season
❒ Moderate to severe pulmonary hypertension (I27.2)
❒ Cyanotic CHD (I24.9)
❒ Meds for CHD: _____ Date CHD med last received: _____
❒ Compromised handling of secretions **and** < 12 months of age at start of season due to:
  ❒ Significant abnormality of the airway (attach clinical notes)
  ❒ Neuromuscular condition (attach clinical notes)

Prescription information

Note: Ohio law allows one prescription per preprinted order form. Please use additional forms for more than one prescription.

Medication	Dose	Directions	Quantity	Refills
❒ Synagis® (palivizumab) 50 and/or 100 mg vials	❒ 15 mg/kg IM	❒ IM once monthly (every 28–30 days)	_____ QS to achieve 15 mg/kg dose	_____ (Max 4)
❒ Epinephrine 1:1000 ampule	❒ Inject 0.01 mg/kg	❒ SC as directed for anaphylaxis	Other	None
Supplies: (Supplies will not be sent with shipment unless indicated.)	❒ Administration supplies consisting of: • Alcohol prep pads • 3 mL 25G x 5/8" safety glide syringes • 25G 1" safety glide needles • Curity flexible bandages • 1 mL 25G x 5/8" safety glide syringe supplies for epinephrine (if prescribed) • 19G x 1 1/2" 5M filter needle • 1 mL 27G x 1/2" TB syringe with needle Send quantity sufficient for medication days' supply.			

❒ Skilled nursing visit to provide parent education related to therapy and disease, administer medication as prescribed, assess general status and response to therapy. Visit frequency based on prescribed dosage orders.

Need by date: _____ **Expected date of next injection:** _____

Prescriber and shipping information (please print)

Prescriber: _____ NPI: _____

Ship to: ❒ Patient ❒ Office ❒ Other: _____

Office address: _____ City: _____ State: _____ ZIP code: _____

Office phone number: _____ Office fax number: _____

Signature: _____ Date: _____

We will dispense this prescription as generic, unless the prescriber indicates "Dispense as Written" here: _____
The prescriber is to comply with his/her state-specific prescription requirements, such as e-prescribing, state-specific prescription form and fax language. Noncompliance with state-specific requirements could result in outreach to the prescriber.