Physician Request Form for Synagis®

Fax to PerformRx at 1-855-811-9326, or to speak to a representative, call 1-888-989-0057.
Form must be completed for processing.

Patient information		
Patient Name		Member ID
Address		Apt. or Suite
City	State	ZIP Code
Phone #		Birth date
Gestational Age at birth: Weeks Days		Next office visit:
Check which months Synagis to be administered: ☐ Nov ☐ Dec ☐ Jan ☐ Feb ☐ Mar		Has infant been dosed prior to discharge from nursery? Yes☐ No☐ If infant was dosed prior to d/c, provide date: _____
Weight: _____lbs. _____oz. = _____kg		

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):

_____

Treatment for BPD/CLD (provide names and dosages for all that apply):

☐Diuretic:_____

☐Bronchodilator:_____

☐Continuous oxygen for at least 28 days after birth:_____

☐Corticosteroids:_____

☐Hospitalizations for BPD/CLD. List hospital and dates: _____

☐Congenital abnormality of the airways

Specify: _____

☐Neuromuscular disease

Specify: _____

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☐Hemodynamically significant congenital heart disease

Specify: _____

Cyanotic? ☐ Yes ☐ No

Congestive heart failure? ☐ Yes ☐ No

☐CHF Medications (provide names and dosages for all that apply):_____

☐Cardiac Transplant

List date of transplant:_____

☐Pulmonary Hypertension

PH Medications (provide names and dosages for all that apply):_____

☐Severe Immunodeficiency

List Diagnosis:_____

☐Any other significant medical information.

List diagnosis, medications, and any hospitalizations:_____

Physician information/delivery information

Physician Name (Print/Stamp)		NPI
Address		Office contact
Suite #/Floor		Fax number
City	State	Phone number
ZIP Code		Date medication required
Physician signature		