mhs health wisconsin

Telephone: 1-800-222-9831
Fax: 1-866-700-0481

Respiratory Syncytial Virus 2019-2020 Enrollment Form

Date: _____ Date Medication Required: _____
Ship to: ❍ Physician ❍ Patient's Home ❍ Other _____

Patient Information

Last Name:	First Name:	Middle:	DOB: ____/____/_____
Address:	City:		State: ▼ Zip:
Daytime Phone:	Evening Phone:		Gender: ☐ Male ☐ Female

Insurance Information (Attach copies of cards)

Primary Insurance:		Secondary Insurance:	
ID #	Group #	ID #	Group #
City:	State: ▼	City:	State: ▼

Physician Information

Name:		Specialty:	NPI:
Address:		City:	State: ▼ Zip:
Phone #: ( )	Secure Fax #: ( )		Office contact:

Primary Diagnosis

ICD-10 Code: _____

☐ Congenital Heart Disease
☐ < 24 weeks of gestation
☐ 29-30 weeks of gestation
☐ 37+ weeks of gestation
☐ Chronic Respiratory disease arising in the perinatal period
☐ 24 weeks gestation
☐ 31-32 weeks of gestation
☐ Other _____
☐ Congenital Abnormality of Respiratory System
☐ 25-26 weeks of gestation
☐ 33-34 weeks of gestation
☐ Cystic Fibrosis
☐ 27-28 weeks of gestation
☐ 35-36 weeks of gestation

Clinical Information ***** Please submit supporting clinical documentation*****

Patient's gestational age (Required): _____weeks _____days Birth Weight: _____ g/kg/lbs Current Weight: _____ g/kg/lbs Date Recorded: _____
Did the patient spend time in the NICU? ☐ Yes ☐ No ***If yes, provide NICU name and attach discharge summary:*** _____
Was this season's first Synagis dose given in the NICU? ☐ Yes ☐ No ***If yes, provide date(s):*** _____ Expected date of first/next injection: _____

Patient Evaluation (Check all that apply and submit clinical documentation):

☐ Hospitalization for RSV infection this season?
☐ Diagnosis of hemodynamically significant Congenital Heart Disease (CHD) and < 12 months of age at start of RSV Season and patient has the following conditions (Check all that apply):
  ☐ Moderate-Severe Pulmonary Hypertension
  ☐ Cyanotic Heart Disease (if consulted with a pediatric cardiologist)
  ☐ Acyanotic heart disease medications to control CHF (list medications): _____ Last Date Received: _____ AND require cardiac surgical procedures
☐ Diagnosis of Chronic Lung Disease* and less than 12 months at start of RSV Season
  *CLD is generally defined as: Infants <32 weeks, 0 days with oxygen requirement > 21% for at least the first 28 days of birth. CLD is NOT defined as asthma, croup, recurrent upper respiratory infections, chronic bronchitis, bronchiolitis, or a history of a previous RSV infection
☐ Diagnosis of Chronic Lung Disease* and between 12 to less than 24 months at start of RSV Season and receiving treatment of (check all that apply and provide last date received):
  ☐ Supplemental oxygen, Date:_____
  ☐ Chronic corticosteroid therapy, Date: _____
  ☐ Diuretic therapy, Date: _____
☐ Diagnosis of Cystic Fibrosis and less than 12 months of age at start of RSV season?
  ☐ Clinical evidence of CLD
  ☐ Nutritional compromise: Explain: _____
☐ Diagnosis of Cystic Fibrosis and between 12 to less than 24 months of age at start of RSV season
  ☐ Manifestations of severe lung disease (hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest radiography or CT that persists when stable)
  ☐ Weight for length less than 10th percentile
☐ Diagnosis of condition that impairs the ability to clear secretions from the upper airway because of ineffective cough *AND* less than 12 months at the start of RSV season
  ☐ Congenital anomaly that impairs the ability to clear secretions from the upper airway because of ineffective cough
  ☐ Neuromuscular condition

Please list other medical history and/or risk factors: _____

Home Health Coordination

Please note, separate authorization is required for injection training/home health visit. Call (800) 222-9831 for prior authorization.
☐ Specialty Pharmacy to coordinate injection training/home health nurse visit as necessary. Please list Agency of choice: _____

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Synagis	☐ 50mg ☐ 100mg	**Inject 15 mg/kg IM one time per month**		
Epinephrine	**1:1000 amp**	**Inject 0.01 mg/kg subcutaneously as directed**		

☐ Prescriber has counseled parent/guardian on Synagis therapy and the specialty pharmacy may contact parent/guardian

Physician's Signature _____ **Date:** _____ ☐ DAW