Medfusion Rx Ascend
Your Time. Your Treatment. Our Specialty.

Synagis Patient Enrollment Form
Fax to 800.218.3221

Phone 800.850.9122
53 Darling Ave. South Portland, ME 04106

Patient (Last, First) _____ DOB _____ Male ☐ Female ☐

Parent/Guardian _____ Home Phone _____
Address _____ Alternate Phone _____
City _____ State & ZIP _____

Please send photo copy of insurance card
PRIMARY INSURANCE _____ ID# _____ Group# _____

Rx Provider _____ Phone# _____
Subscriber Name _____ Subscriber DOB _____ Subscriber SS# _____
SECONDARY INSURANCE _____ ID# _____ Group# _____
Phone# _____ Subscriber Name _____ DOB _____ SS# _____

☐ **Medicaid PA Submitted**

STATEMENT OF MEDICAL NECESSITY AND PERTINENT MEDICAL HISTORY

Patient Gestational Age REQUIRED * _____ *

☐ Congenital Heart Disease (745.0–747.9) ☐ Chronic Respiratory Disease Arising in the Perinatal Period (CLD) (770.7)
☐ Other _____

List Meds and Dates _____

ADDITIONAL RISK FACTORS

☐	School-age Siblings	☐	Daycare Attendance	☐	Congenital Airway Abnormalities	☐	Low Birth Weight (<2500g)	☐	Crowded Household	☐	Prior Hospitalization for RSV
☐	Environmental Pollutants	☐	Neuromuscular Disease	☐	Multiple Birth	☐	Ext. Low Birth Weight <1000g	☐	Anticipated Cardiac Surgery	☐	Family History of Asthma

NOTES _____

BIRTH WEIGHT _____ CURRENT WEIGHT _____ Date Measured _____

PHYSICIAN INFORMATION AND PRESCRIPTION FOR SYNAGIS

Physician _____ NPI# _____
Practice Name _____ DEA# _____
Address _____ Phone# _____
Medicaid Prescriber # _____ Office Contact _____ Fax # _____

Synagis 100mg and/or 50mg vial(s) as needed based on patient weight.
Sig: 15mg per kg of body weight once per month.

☐ NEXT injection OR
☐ FIRST injection due

DATE:

Refill PRN (through RSV season).

HAS FIRST DOSE BEEN GIVEN? ☐ YES ☐ NO IF YES, WHEN? _____ WHERE? _____

SUBSEQUENT injections will be administered IN ☐Hospital ☐ MD Office ☐Patient's Home ☐Other _____

☐ Check here to have Ascend SpecialtyRx coordinate nursing for in-home injections.
Preferred home health agency, if any _____ Already in the home? _____

Physician Signature _____ Date _____