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**

Last **First**
Patient_______________________________ **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#**______________
Rx Provider_______________________________ **Phone#**______________
Subscriber Name______________ **Subscriber DOB**______________ **Subscriber SS#**______________
Medicaid PA Submitted

STATEMENT OF MEDICAL NECESSITY AND PERTINENT MEDICAL HISTORY

Patient Gestational Age REQUIRED * ______________ *

765.21-765.29 Prematurity
770.7 Chronic Lung Disease Arising in Perinatal Period
770.0-770.9 Other Respiratory Conditions of the Fetus and Newborn
__________ Congenital Heart Disease (specify ICD-9 and diagnosis)
__________ Compromised Immune Function (specify ICD-9 and diagnosis)
__________ Other Condition (specify ICD-9 and diagnosis)

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 _______________________________
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Birth Weight______________ **Current Weight**______________ **Date Measured**______________

PHYSICIAN INFORMATION AND PRESCRIPTION FOR SYNAGIS

Referring Physician_______________________________ **NPI#**______________
Practice Name_______________________________ **DEA#**______________
Address_______________________________ **Phone#**______________
Following 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______________