Prescription & Enrollment Form
Synagis

(800) 962-6339 Office
(866) 755-6339 Fax

Patient Information

Last Name	First Name
Social Security #	Date of Birth
Parent or Guardian	
Home Phone	Other Contact Phone
Home Address	
City, State, Zip	

Insured Information

Primary Insurance (Fax copy of card - both sides)	
Subscriber's Name	Relationship to Patient
Policy #	Group #
Primary Insurance Phone	
Prescription Card (Fax copy of card - both sides)	
Secondary Insurance	Policy #

DIAGNOSIS/MEDICAL INFORMATION (Please specify primary and secondary diagnosis)

☐ 765.0 Extreme Immaturity (less than 27 wks gestation)	
☐ 765.1 Immaturity (28-37 wks gestation)	
☐ 770.7 Chronic Respiratory Disease arising in the neonatal or perinatal period	
☐ Other ICD-9 - Please specify:	
Gestational Age at Birth (weeks):	Allergies:
Birth Weight: kg/ lbs	
Current Weight: kg/ lbs	

RISK FACTORS (Please circle)

Is the patient in contact with siblings?	Yes	No	Does the patient attend day care?	Yes	No
Congenital airway abnormalities?	Yes	No	Is the patient exposed to smoke?	Yes	No
Twin/Multiple Births?	Yes	No			
Neuromuscular Disease?	Yes	No	Specify:		
Other? Please explain					

PRESCRIPTION INFORMATION

Medication	Dose	Frequency	Quantity	Refills
☐ Synagis 100mg vial Liquid Solution				
☐ Synagis 50mg vial Liquid Solution				
☐ Other				

DELIVERY INSTRUCTIONS

☐ Physician's Office ☐ Patient's Home ☐ Other	Date Medication Needed:

Physician's Name (Please Print)

Physician's Address

Physician's Signature Date

Phone Fax

Physician's DEA#

Dr.'s Office Contact Name

License # NPI#

Fax completed form to Medex BioCare (866) 755-6339