RSV Prevention Referral Form

____ Pharmacy Only ____ Clinic Referral

Alliance Ambulatory Infusion Center **Phone: (817) 923-4495** **Toll Free: (866) 923-4495** **Intake Fax: (866) 923-4492**

Corporate Office	Desoto	Houston	Tyler	San Antonio
1512 8th Ave. Suite 100	2727 Bolton Boone Dr. Ste 110	1919 N. Loop West, Ste 180	837 S. Fleishel	211 North San Saba, Suite 205
Fort Worth, TX 76104	Desoto, TX 75115	Houston, TX 77008	Tyler, TX 75701	San Antonio, TX 78207

Name: ____ Male___ Female___
Parent or Guardian:____________________________________ Date of Birth:______________ SS#:______________________
Address:____ City:___________________________St.________ Zip_________
Home Phone:___________________ Work Phone:____________________ Cell Phone:________________
Emergency Contact Name____ Relationship_________________________

Primary Insurance: ___________________________________
Phone #:____
Subscriber: ____________________________ DOB: _______
ID#: ___________________ Policy/Group #: _____________
Employer:____

Secondary Insurance: ________________________________
Phone #:____
Subscriber: ____________________________ DOB: _______
ID#: ___________________ Policy/Group #: _____________
Employer____

Prescription Drug Card: Name ______________________________ Group# _________________ ID# ____________________

Primary Diagnosis: ________________ (Please note correct ICD9 Code and a brief description:)________________________________
____

Birth weight:_____lbs ____oz Current weight:____ lbs ____oz Date Recorded___________
Gestational age at birth: ______(weeks) Must have 2 risk factors for infants greater than 32 weeks.
Prematurity:
- ___Gestational age of ≤28 weeks and <12 months of age at the start of RSV season
- ___Gestational age of ≤29-32 weeks and <6 months of age at the start of RSV season
- ___Gestational age of ≤32-35 weeks and <6 months of age at the start of RSV season

___76500 Extreme immaturity, unspecified weight
___76501Extreme immaturity, less than 500 gm
___76502 Extreme immaturity, 500-749 gm
___76503 Extreme immaturity, 750-999
___76504 Extreme immaturity, 1000-1249 gm
___76505 Extreme immaturity, 1250-1499 gm
___76506 Extreme immaturity, 1500-1749 gm
___76507 Extreme immaturity, 1750-1999 gm
___76508 Extreme immaturity, 2000-2499 gm
___76510 Other preterm infants, unspecified weight
___76511 Other preterm infants, less than 500 gm
___76512 Other preterm infants, 500-749 gm
___76513 Other preterm infants, 750-999 gm
___76514 Other preterm infants, 1000-1249 gm
___76515 Other preterm infants, 1250-1499 gm
___76516 Other preterm infants, 1500-1749 gm
___76517 Other preterm infants, 1750-1999 gm
___76518 Other preterm infants, 2000-2499 gm
___7707 Chronic respiratory disease

Medical Criteria to Include ICD9 Codes
___ Chronic Pulmonary Disease (CLD/BPD) and less than 24 months of age? ___yes ___no __________ICD9Code
___ Hemodynamically significant congenital heart disease and less than 24 months of age? ___yes ___no __________ICD9 Code
___ Diagnosis of moderate-severe pulmonary hypertension ___yes ___no
Is the Patient currently on any medications? ___yes ___no
List medications: ____
____

Clinically has the following risk factors (check all that apply):
___School-age siblings ___Exposure to environmental air pollutants
___Day care ___Severe neuromuscular disease
___Congenital abnormality of airway ___Family history of asthma
___Birth weight less than 2500 grams ___Crowded living conditions ___Multiple birth
Allergies:____
Other medical history: ____
____

NICU HISTORY:
Did the patient spend time in the NICU? ___Yes ___No If yes, please attach the NICU Discharge Summary
Has patient received Synagis before? ___yes ___no
If yes, date of last injection:____________________________________

Prescription:
Synagis (Palivizumab) 50 and/or 100 mg vials and Sterile Water for injection 10 ml (for lyophilized formulation only)
SIG: Reconstitute as directed (for lyophilized formulation only) and inject 15 mg/kg IM one time every 28 days.
Refill___________ months
Epinephine 1:1000 amp. Sig: Inject 0.01 mg/kg as directed
Known Allergies:_________________________________
May use ready mixed Synagis when available, 15mg/kg
Other: ____

Physician Certification: _________TPI # _________ UPIN# _________Tax ID# ___________DEA # ________________NPI #
Prescriber's Signature____Date _____________
Supervising Physician's Signature:____Date _____________
Print Name:____
Address:____ City___________________________ State______ Zip_________
Phone:_________________________ Fax:_________________________ Email:___________________________ **Thank you for your referral.**

AAIC Pharmacy

Please send front and back copies of all insurance cards with referral.

6-26-07