KEYSTONE MERCY HEALTH PLAN

A Program of Keystone First and Mercy Health Plan

Physician Request Form for Synagis®

Fax to Keystone Mercy Pharmacy Services at 215-937-5018, or to speak to a representative call **800-588-6767**. *Form must be completed for processing.*

Patient Name: ____________________ Keystone Mercy ID#: ____________________

Address: ____________________ Apt # or Suite #: ____________________

City: ____________________ State: __________ Zip Code: ____________________

Phone #: __________ ____________________ Birth Date: ____________________

Actual Gestational Age: Weeks Days	Next Clinic Visit:
Chronological Age: Months Weeks	Has Infant been dosed prior to d/c from Nursery? Yes ☐ No ☐ If infant was dosed prior to d/c, when:
Weight: ________lbs_______oz. = __________Kg Dose: 15 mg /kg x __________Kg = ____________ mg	Check which Months Synagis to be administered: Nov ____, Dec____, Jan____ Feb ____, Mar____

Medical Risk Factors (Check where applicable and provide details as noted. Please attach any needed documentation)

☐ Bronchopulmonary Dysplasia (BPD) aka Chronic Lung Disease (CLD). Please provide information of how it was diagnosed (i.e. x-ray)____________________

Medications for BPD/CLD (provide names and dosages for all that apply):

- ☐ Diuretic: ____________________
- ☐ Bronchodilator: ____________________
- ☐ Oxygen: prn or daily? ______________ # Liters____________________
- ☐ Other: ____________________

Hospitalizations for BPD/CLD. List hospital and dates: ____________________

☐ Congenital abnormality of the airways: Specify: ____________________

☐ Neuromuscular disease: Specify: ____________________

☐ Hemodynamically significant congenital heart disease. Diagnosis: ____________________

Cyanotic? YES______ NO______ Congestive Heart Failure YES______ NO______

CHF Medications. List name and dosage: ____________________

☐ Pulmonary Hypertension? Medications for pulmonary hypertension?____________________

☐ Severe Immunodeficiency? YES______ NO______ If, Yes, list Diagnosis: ____________________

Please only fill out for Gestational Age 32 to less than 35 weeks AND under 3 months of age (provide as much detail as possible)

☐ Patient attends daycare. Name of daycare: ____________ Number of days per week: __________ Number of hours per day: __________

☐ Siblings. Please list number of siblings and their ages: ____________________

☐ Other- List all that you think apply: ____________________

☐ Any other significant medical information. List diagnosis, medications, and any hospitalizations. ____________________

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Physician Information/Delivery Information

Physician Name (Print/Stamp): ____________________ NPI # ____________________

Mailing Address ____________________ Office Contact: ____________________

Suite # / Floor: ____________________ Fax Number: ____________________

City: ____________________ Phone Number: ____________________

State: ______________Zip Code: ____________________ Physician Signature: ____________________

Date Medication required: ____________________

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