JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100
Hanover, MD 21076

SYNAGIS Referral Form

FOR PROVIDER USE ONLY

Complete and fax this form and prescription to EHP at 410-424-2801

For questions regarding this form, contact the Pharmacy department at 410-424-4490 option 4 or 1-888-819-1043 option 4

For Internal Use Only
PA#:
Date Entered:

Patient Information		**Physician Information**	
Member name:		Physician Name:	
Member ID#:		Office Contact:	
Date of Birth:	☐Male ☐Female	Office Phone:	Office Fax:
Parent Guardian :		DEA #	

Prescription Information (Prescription for SYNAGIS MUST be attached)

SYNAGIS Vial Quantity:100 mg _____ 50 mg _____ SIG: Inject 15mg/kg IM one time per month Desired Start Date: _____ Refill: _____months	Birth Weight: _____ in lbs. or kg (circle one) Current Weight: _____ in lbs. or kg (required) Actual Gestational Age: _____ weeks (required)

Approval Criteria *(If applicable, attach NICU discharge summary and/or supporting progress notes)*

- ☐ Age of 12 months or less & born at 29 weeks or less gestation at beginning of RSV season
- ☐ Age of 12 months or less with Chronic Lung Disease (CLD/bronchopulmonary dysplasia) plus the following:
  - ☐ born at less than 32 weeks gestation AND requires >21% oxygen for at least 28 days after birth
- ☐ Age of 12 months or less with hemodynamically significant Congenital Heart Disease plus one of the following:
  - ☐ acyanotic heart disease & receiving medication to control congestive heart failure & requires heart surgery
  - ☐ moderate to severe pulmonary hypertension
- ☐ Age of 12 months or less plus one of the following that compromises clearing secretions from upper airway:
  - ☐ anatomic pulmonary abnormalities
  - ☐ neuromuscular disorder
- ☐ Age of 23 months or less with severe immunodeficiency
- ☐ Age of 23 months or less with CLD/bronchopulmonary dysplasia requiring treatment within 6 months prior to RSV season (born at less than 32 weeks gestation AND required >21% oxygen for at least 28 days after birth) and requires one of the following medical support:
  - ☐ oxygen ☐ diuretics ☐ corticosteroid
- ☐ Age of 23 months or less at the start of RSV season plus one of the following:
  - ☐ undergoing heart transplant
  - ☐ receiving prophylaxis & requires one additional post-operative dose
- ☐ Age of 23 months or less with Cystic Fibrosis and meets one of the following:
  - ☐ CLD and/or nutritional compromise at the age of 12 months or less
  - ☐ manifestations of severe lung disease during second year of life

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- ☐ Office Reimbursement Requested. Provider will administer SYNAGIS from office inventory and bill JHHC for reimbursement
- ☐ Arrange Specialty Pharmacy Delivery. JHHC will arrange office delivery from specialty pharmacy. The specialty pharmacy will contact provider office for confirmation prior to shipment.

I certify that the clinical information provided on this form is complete and accurate.
Provider Signature: _____ **Date:** _____

For Internal Use Only	**Per CDC, SYNAGIS season in the state of MD is from Nov –Mar**
☐ Approved Number of Doses _____	Duration of Approval:
☐ Denied	Reviewer:
Need more information:	Date: