E-Scribe and Fax
ENROLLMENT FORM

NOBLE HEALTH SERVICES

☐ **NOBLE NEW YORK**
Tel: 888-843-2040
Fax: **888-842-3977**

☐ **NOBLE MISSISSIPPI**
Tel: 866-420-4041
Fax: **601-420-4040**

Synagis®
PALIVIZUMAB

Delivery Need By: _____ Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Other _____

PATIENT INFORMATION

Patient Name (Last, First, MI): _____ ☐ Male ☐ Female

Date of Birth: _____ Birth Weight: _____ lb _____ oz or _____ grams

Current Weight: _____ lb _____ oz Or _____ kg On date: _____ /_____ /_____

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name: _____ Primary Language: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #:_____ Mobile Phone #: _____

Email Address: _____

Preferred Contact Method: ☐ Phone ☐ Text ☐ Email

INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

INSURANCE INFORMATION

Policyholder Full Name: _____ Policyholder Date of Birth: _____

Primary Medical Insurance: _____

Insurance Phone #: _____ Employer: _____

Group #: _____ Policy #: _____ ID #: _____

Secondary Medical Insurance: _____ Insurance Phone #: _____

Group #: _____ Policy #: _____ ID #: _____

Pharmacy Benefit: _____ **RxBIN**: _____ **RxPCN**: _____

Cardholder Name: _____ Social Security #: _____

MEDICAL CRITERIA (ATTACH REQUIRED DOCUMENTATION)

☐ **Prematurity:** Gestational age _____ (weeks/days) ICD 10: _____

Bronchopulmonary dysplasia (BPD)/chronic lung disease (CLD)

☐ Aged <12 months

☐ Aged 12 to <24 months

☐ Supplemental oxygen (dates): _____ ☐ Chronic corticosteroids (drugs/dates): _____

☐ Diuretic therapy (drug/dates): _____ ☐ Bronchodilators (drugs/dates): _____

Diagnosis: _____ ICD-10: _____

Hemodynamically significant congenital heart disease

☐ Aged <12 months

☐ Aged 12 to <24 months

Diagnosis: _____ ICD-10: _____

Other conditions

Description:_____

Diagnosis: _____ ICD-10: _____

V.Q220201G

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PHYSICIAN INFORMATION

Prescriber Name: _____

License #: _____ NPI #: _____ DEA #: _____

Practice Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

SYNAGIS ® (palivizumab) Coordinator: _____ Phone #: _____

PRESCRIPTION INFORMATION

NICU/Hospital Dose Administered: ☐ Yes ☐ No Date(s): _____

Needs by date: _____ Expected Date of First/Next Injection: _____

Current Medications: _____

Known Allergies: _____

Rx SYNAGIS 50-mg and/or 100-mg vials. Please indicate the required number of vial(s) to achieve 15-mg/kg dose.

☐ **SYNAGIS 50 mg**: Inject 15 mg/kg intramuscular once per month (every 28-30 days) **Quantity** _____
Refills: (Please enter "0" if no refills remain) _____
(Required)

Prescriber Signature: _____

Date: _____

☐ **SYNAGIS 100 mg:** Inject 15 mg/kg intramuscular once per month (every 28-30 days) **Quantity** _____
Refills: (Please enter "0" if no refills remain) _____
(Required)

Prescriber Signature: _____

Date: _____

☐ **Epinephrine 1:1000 amp**: Inject 0.01 mg/kg SubQ as directed

Quantity: 1 ampule. No refills.

Prescriber Signature: _____ Date: _____

☐ Ancillary supplies and kits provided as needed for administration

DELIVERY INFORMATION

Deliver to:

☐ Office/Clinic ☐ Patient's Home ☐ Other _____

Home Health Services Preferred for Injection Administration? ☐ Yes ☐ Currently Receiving ☐ No

Home Health Agency Name: _____

Home Health Agency Contact: _____ Home Health Agency Phone #: _____

Prescriber Signature: _____ Date: _____

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