CenterWell™ Specialty Pharmacy

Synagis Prescription Order Form

E-prescribe: NCPDP ID number 3677955
Fax: 800-345-8534
Phone: 855-264-0104
Monday – Friday, 8 a.m. – 11 p.m., and
Saturday, 8 a.m. – 6:30 p.m., Eastern time

Primary diagnosis

❑<24 weeks GA* (765.21)
❑24 weeks GA (765.22)
❑25–26 weeks GA (765.23)
❑27–28 weeks GA (765.24)
❑29–30 weeks GA (765.25)
❑31–32 weeks GA (765.26)
❑33–34 weeks GA (765.27)
❑35–36 weeks GA (765.28)
❑37 or more weeks GA (765.29)
❑Congenital heart disease (745.4-747.9)
❑Severe neuromuscular disease (358)
❑Congenital anomalies of the airway (748)

❑Chronic respiratory disease arising in the perinatal period (CLD) (770.7)

❑Other respiratory conditions of the fetus and newborn (770.0-770.9)

Risk factors

❑Child care attendance outside of home

❑Living with child under five years of age

Medical criteria

❑Diagnosis of chronic pulmonary disease and ≤24 months of age at the start of respiratory syncytial virus (RSV) season

Patient receiving medical treatment:
❑ Oxygen date: _____ ❑ Corticosteroids date: _____
❑ Bronchodilator date: _____ ❑ Diuretics date: _____

❑Diagnosis of hemodynamically significant congenital heart disease (CHD) and ≤24 months of age at the start of RSV season

❑ Cyanotic heart disease ❑ Acyanotic heart disease

❑ Moderate to severe pulmonary hypertension
Medications for CHF/CHD: ❑ No ❑ Yes

You can send this prescription electronically (eRx) by selecting "Humana Specialty Pharmacy (Now CenterWell Specialty Pharmacy)" (NCPDP ID # 3677955) from the list of pharmacies on your e-prescribing tool.

*GA – Gestational age

Patient name: _____ Date: _____
Patient address: _____
Date of birth: _____
Drug allergies: _____

Patient's GA**:** _____ weeks _____ days

Birth weight**:** _____Current weight: _____ Date recorded: _____

Multiple-birth siblings ❑Twin ❑Triplet ❑Quad ❑Other

Height: _____

Prescription information

❑ Synagis® (palivizumab) **Sig:** Inject 15 mg/kg IM every 28–30 days
Dispense quantity: Quantity sufficient (QS) for total of _____ **doses**
(maximum five doses for season)

❑ Synagis supply kit: (1cc 25g 5/8") **Quantity:** 2; QS for total of _____ doses

❑ epinephrine 1:1000 amp. **Sig:** Inject 0.01 mg/kg SC as directed

Was a newborn intensive care unit/hospital dose administered? ❑ Yes ❑ No

First dose date: _____ Second dose date: _____

Expected date of first/next injection: _____
Deliver to: ❑ Physician's office ❑ Home
❑ Home health nurse to administer injections; Agency: _____

Office contact _____

Prescriber name: _____
Prescriber address: _____
DEA number: _____ NPI:_____

Phone: _____ Fax: _____

Prescriber signature: _____ **Date**: _____

*Note: All requested information must be provided manually. We cannot accept information provided via stamp pads.

Please provide supervising prescriber information (if applicable):
Name: _____
Address: _____
Phone: _____
DEA number: _____ NPI number:_____