reliance|rx℠

45 Earhart Drive, Suite 110,
Amherst, NY 14221

1 Specialty Pharmacy: **Reliance Rx** Fax Number: **716-532-7360** Phone: **716-929-1000**

- ☐ If specialty pharmacy provider options are not known, please check here to request research to identify Specialty Pharmacy Provider options
- ☐ This is a home health agency

2 **PATIENT INFORMATION**

Last Name | First Name | Middle Initial

Street address | City

Country | State | Zip Code

Date of Birth | Social Security Number | Gender ☐ M ☐ F

Primary Guardian | Secondary Guardian

Day telephone (+ area code) | Night telephone (+ area code)

Patient is one of multiple births ☐ Yes ☐ No

If yes, is sibling(s) referral being submitted simultaneously? ☐ Yes ☐ No

Sibling name(s) _____

INSURANCE INFORMATION

Include copies of the patient's insurance cards and drug benefit cards (front and back) to expedite benefit clearance

Primary Insurance | Secondary Insurance

Cardholder name & Social Security number (if not patient) | Cardholder name & Social Security number

Policy Number(s) | Policy Number(s)

Group Number(s) | Group Number(s)

Insurance telephone number (+ area code) | Insurance telephone number (+ area code)

Employer | IPA

3 **PHYSICIAN INFORMATION**

Prescriber's Name | Site Name | Office Contact

Address | Cite/State/Zip | Phone Number

Prescriber's License Number | DEA Number | Fax Number (+ Area Code)

Medicaid Provider Number | Tax ID Number | NPI Number

Supervising Physician's name (if required for mid-level practitioner) | License Number

4 **CLINICAL INFORMATION**

PRIMARY DIAGNOSIS:

PATIENT'S GESTATIONAL AGE (GA) _____ BIRTH WEIGHT _____ lb. or _____kg

CURRENT WEIGHT _____ lb. or _____kg DATE CURRENT WT. RECORDED_____

☐ Congenital heart disease (.0-747.9)	☐ 29-30 completed weeks of gestation (765.25)
☐ Chronic respiratory disease arising in the perinatal period (770.7)	☐ 31-32 completed weeks of gestation (765.26)
☐ <24 completed weeks of gestation (765.21-765.22)	☐ 33-34 completed weeks of gestation (765.27)
☐ 25-26 completed weeks of gestation (765.23)	☐ 35-36 completed weeks of gestation (765.28)
☐ 27-28 completed weeks of gestation (765.24)	☐ >37 completed weeks of gestation (765.29)
☐ Other respiratory conditions of fetus or newborn (770.0-770.9)	☐ Congenital anomalies of respiratory system (748)
☐ Other _____	Secondary Diagnosis(If applicable)_____

MEDICAL CRITERIA:

1. ☐ Diagnosis **of chronic lung disease/bronchopulmonary disease (CLD/BPD**) and <24 months of age?
   Is patient receiving medical treatment of (check all that apply and provide date last received?)
   ☐ Oxygen date:_____ ☐ Corticosteroids date:_____ ☐ Bronchodilator date: _____
   ☐ Diuretics date:_____
2. ☐ Diagnosis of hemodynamically **significant congenital heart disease (CHD**) and < 24 months of age?
   Patient has the following condition:
   ☐ Medications for CHD: _____ Last date received: _____
   ☐ Diagnosis of moderate to severe pulmonary hypertension ☐ Cyanotic CHD
3. ☐ Infant <12 months of age as of November 1st with **Cystic Fibrosis (CF)** diagnosed by positive sweat test or 2 mutations and clinical evidence of CLD and/or nutritional compromise
   ☐Infant in 2nd year of life with manifestations of severe lung disease (previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest radiography or chest computed tomography that persist when stable or weight for length is less than 10th percentile)
4. ☐ Child <24 months of age at the start of Synagis season who received a **solid organ transplantation** during RSV season
5. ☐ Child <24 months of age at start of Synagis season who are **profoundly immunocompromised** during RSV season: Check all that apply
   ☐ Human immunodeficiency virus ☐ receiving treatment for cancer ☐ Hematopoietic stem cell transplantation ☐ Corticosteroid therapy ☐ Any degree of lymphopenia
6. ☐ Child with **pulmonary abnormality or neuromuscular disease** that impairs the ability to clear secretions

HOSPITAL HISTORY:

Did the patient spend time in the NICU/PICU/special care nursery? ☐ Yes ☐ No
If yes, please attach the discharge summary
Was therapy recommended by the hospital physicians for this patient? ☐ Yes ☐ No
Was therapy administered in the NICU/hospital? ☐ Yes ☐ No

EXPECTED DATE OF FIRST/NEXT DOSE: _____ Dose already given? ☐ Yes Date: _____ ☐ No
Please complete month and date to indicate if next dose is to be given.

Deliver product to ☐ Office ☐ Patient's home ☐ Clinic: Location: _____
Agency nurse to visit home for injection? ☐ Yes ☐ No Agency name: _____

Rx: Prescribed medication: _____ **Refill monthly:** _____ **Months:** _____
Dosing: _____
☐ **Epinephrine 1:1000 amp. Sig: Inject 0.01 mg/kg SC as directed**
Known allergies: _____

I hereby grant the RSV Connection program limited agency to convey on my behalf to the pharmacy chosen by or for the above- named patient, the prescription prescribed herein.
Prescriber Signature: _____ **Date:** _____
Signature and date must be provided