SYNAGIS STATEMENT
OF MEDICAL NECESSITY
Fax: 270-247-6033
or 270-251-3571

DUNCAN
SPECIALTY PHARMACY

317 W. Broadway
Mayfield, KY 42066

Phone: 270-247-3725

Today's Date: Needs by Date:

Ship to: ☐ Patient ☐ Office ☐ Other:

Patient Information	Prescriber Information
Patient Name:	Prescriber Name:
Address:	Practice Name:
City, State, Zip:	Address:
Home & Cell #:	City, State, Zip:
SSN:	DEA #: State License #:
DOB: Sex:	NPI#:
Drug Allergies:	Phone: Fax:
Patient one of multiple births? ☐ Yes ☐ No	Contact Person:
If yes, is sibling(s) referral being submitted simultaneously? ☐ Yes ☐ No	Patient Insurance Name:
Sibling Names:	Policy#/Patient ID#:

INSURANCE INFORMATION: Please fax front & back copy of Medical & Prescription card(s) if possible:

Clinical Information—Statement Of Medical Necessity

Patient's Gestational Age (GA) at birth: Birth weight: ☐ Medical records included

Current weight: lbs-oz kg Date current weight recorded:

List Patient Medications:

☐ **BPD/CLDP: Diagnosis of bronchopulmonary dysplasia/chronic lung disease of prematurity and ≤ 24 months of age.**

Diagnosis code:

Is patient receiving medical treatment (check all that apply and provide last date received)?

☐ Oxygen date: ☐ Corticosteroids date: ☐ Bronchodilators date: ☐ Diuretics date:

☐ **CHD: Diagnosis of hemodynamically significant congenital heart disease and ≤ 24 months of age.**

Diagnosis code:

Patient has any of the following (check all that apply): ☐ Cyanotic CHD ☐ Moderate to severe pulmonary hypertension

☐ Medications for CHD:

☐ Date CHD medications were last received:

☐ **Indicate applicable risk factors:**

☐ Congenital abnormality of airways ☐ Severe neuromuscular disease ☐ Residency in rural setting

☐ Family history of asthma or wheezing ☐ Pre-school or school-aged siblings (<5 years of age) ☐ Multiple births

☐ Exposure to environmental tobacco smoke or air pollutants ☐ Daycare- care at any home or facility w/ any number of infant or young toddlers

Was Synagis previously administered (NICU/hospital/other location)? ☐ Yes ☐ No Dates administered:

Expected date of first/next dose:

Nurse to visit home for injection? ☐ Yes ☐ No Agency Name:

Prescription Information

✓	MEDICATION		DIRECTIONS	QTY	REFILLS
☐	SYNAGIS	☐ 50 and/or 100mg vials	☐ Inject 15mg/kg IM every 28-30 days		
☐	EPINEPHRINE (Home Health Patients Only)	☐ 1:1000 amp	☐ Inject 0.01 mg/kg IM/SC as directed		

Revised 10/23/19

Prescriber Signature: Date:

By signing this form & utilizing our services, you are authorizing Duncan Specialty Pharmacy & its employees to serve as your prior authorization designated agent in dealing with medical & prescription insurance companies. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials to another pharmacy of the patient's choice or within his/her provider network