

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

Patient Name:

Address:

City, State, Zip:

Home & Cell #:

SSN:

DOB:

Sex:

Drug Allergies:

Patient one of multiple births?  Yes  No

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

Sibling Names:

### Prescriber Information

Prescriber Name:

Practice Name:

Address:

City, State, Zip:

DEA #:

State License #:

NPI#:

Phone:

Fax:

Contact Person:

Patient Insurance Name:

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
<input type="checkbox"/>	SYNAGIS <input type="checkbox"/> 50 and/or 100mg vials	<input type="checkbox"/> Inject 15mg/kg IM every 28-30 days		
<input type="checkbox"/>	EPINEPHRINE (Home Health Patients Only) <input type="checkbox"/> 1:1000 amp	<input type="checkbox"/> Inject 0.01 mg/kg IM/SC as directed		

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

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