

Enroll online at www.CoverMyMeds.com. Fax to SYNAGIS CONNECT™ at **1.800.201.4938** or to patient's preferred Specialty Pharmacy.

Buy-and-Bill Benefit Preferred Specialty Pharmacy _____

PATIENT INFORMATION Please indicate if multiple births.

Last Name: _____ First Name: _____ Middle Initial: _____
 Date of Birth: ____/____/____ Sex: Male Female Birth Weight: _____ lb _____ oz OR _____ kg
 Current Weight: _____ lb _____ oz OR _____ kg Date of Weight: ____/____/____

PARENT/CAREGIVER INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____
 Street: _____ Unit: _____ City: _____ State: _____ ZIP Code: _____
 Home Phone #: _____ Mobile Phone #: _____
 Email: _____ Preferred Contact Method: Phone Text Email
 Best Time to Call: Morning Afternoon Evening Preferred Language: _____

I authorize SYNAGIS CONNECT™ to send text messages when appropriate and hereby agree to receive this type of communication. Standard data and message rates may apply.

I authorize SYNAGIS CONNECT™ to leave a detailed message, including the name of my child's prescription, SYNAGIS.

Enroll me in the SYNAGIS Copay Program. Eligibility requirements apply.

INSURANCE INFORMATION Please provide a copy of all insurance cards (front and back). No Insurance

Policyholder Full Name: _____ Policyholder Date of Birth: ____/____/____
 Primary Medical Insurance: _____
 Insurance Phone #: _____ Group #: _____ ID #: _____
 Secondary Medical Insurance: _____
 Insurance Phone #: _____ Group #: _____ ID #: _____
 Prescription Insurance: _____ RxGroup: _____ RxBIN: _____ RxPCN: _____

▼ FOR HEALTHCARE PROVIDER USE ONLY ▼

PRESCRIBER INFORMATION

Last Name: _____ First Name: _____ Office/Institution Name: _____
 Street: _____ Suite: _____ City: _____ State: _____ ZIP Code: _____
 NPI #: _____ DEA #: _____ Tax ID #: _____
 Medicaid Provider ID #: _____
 Office Contact Name: _____ Phone #: _____
 Fax #: _____ Email: _____

CLINICAL INFORMATION Attach any required clinical notes.

<input type="radio"/> Prematurity: _____ weeks'/days' GA ICD-10: _____ <input type="radio"/> Other conditions: Description: _____ Diagnosis: _____ ICD-10: _____	<input type="radio"/> Bronchopulmonary dysplasia/chronic lung disease <input type="radio"/> Age <12 months <input type="radio"/> Age 12 months to <24 months Supplemental oxygen (dates): _____ Chronic corticosteroids (drugs/dates): _____ Diuretic therapy (drug/dates): _____ Bronchodilators (drugs/dates): _____ ICD-10: _____	<input type="radio"/> Hemodynamically significant congenital heart disease <input type="radio"/> Age <12 months <input type="radio"/> Age 12 months to <24 months ICD-10: _____
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NICU/Hospital dose administered: No Yes Date(s): _____ Needs by date: _____ Expected date of first/next injection: _____
 Current medications: _____ Known allergies: _____
 Deliver to: Office/Clinic Patient's Home Other _____
 Home Health Agency Services Requested for Injection Administration No Yes Preferred Home Health Agency _____

MEDICATION	STRENGTH	DOSE & DIRECTION	QUANTITY & REFILLS
SYNAGIS® (palivizumab)	50 mg and/or 100 mg vials	Inject 15 mg/kg IM one time per 28-30 days	Quantity: QS to achieve 15 mg/kg dose Refills: _____
<input type="radio"/> OPTIONAL: Epinephrine	1:1000 amp	Inject 0.01 mg/kg SC as directed for anaphylaxis	Quantity: _____ Refills: _____

Ancillary supplies

Stamp Signature Not Allowed

OR

Prescriber Signature _____	Date _____
<i>Dispense as Written</i>	
Prescriber Signature _____	Date _____
<i>Substitution Permitted</i>	

PRESCRIBER AUTHORIZATION: My signature certifies that the person named on this form is my patient; that the information provided, to the best of my knowledge, is complete and accurate; and that therapy with SYNAGIS is medically necessary. I certify that I have obtained the written authorization of my patient's parent or caregiver in accordance with all applicable state and federal laws to release the individually identifiable health information included on this form to Sobi and SYNAGIS CONNECT™ patient support program and I understand that the information that I provide on this form will be used by the program for purposes of verifying my patient's insurance coverage and eligibility; coordinating the dispensing of my patient's prescription medicine; and introducing SYNAGIS CONNECT™ support services to my patient, including contacting my patient's parent/caregiver by telephone or mail for these purposes. I authorize SYNAGIS CONNECT™ to transmit the above prescription to the appropriate specialty pharmacy for my patient. I understand that I am under no obligation to prescribe any Sobi products and that I have not received nor will I receive any benefit from Sobi for doing so. I will not seek reimbursement from any third-party payer or government entity for any product provided free of charge by SYNAGIS Connect.

Special Note: Prescribers in all states must follow applicable laws for a valid prescription. For prescribers in states with official prescription form requirements, please submit an actual prescription along with this enrollment form.

SIGN HERE Prescriber Signature _____ Date _____

Patient Last Name: _____ First Name: _____ Date of Birth: _____

AUTHORIZATION TO SHARE HEALTH INFORMATION:

By signing below, I authorize my child's healthcare providers and staff, pharmacies, and health insurers to use and to disclose to Sobi, Inc., and its affiliates, business partners, vendors, and other agents (collectively, "Sobi") health information about my child related to my child's medical condition and treatment, health insurance and coverage claims, and prescription (including fill/refill information) for SYNAGIS ("Information") to (1) enroll my child in and provide services under the SYNAGIS CONNECT™ patient support program (the "Program"); (2) obtain information on my child's insurance coverage; (3) coordinate prescription fulfillment as indicated by my child's physician; (4) provide me with adherence reminders and support; and (5) contact me to conduct market research and to arrange for my receipt of educational, promotional, and/or marketing materials about Sobi support programs or Sobi products. Once my child's Information has been disclosed to Sobi, I understand that federal privacy laws may no longer protect it from further disclosure. However, I also understand that Sobi will protect my child's Information by using and disclosing it only for the purposes allowed by me in this Authorization or as otherwise required by law.

I understand and agree that the pharmacy that dispenses SYNAGIS may receive payment from Sobi in exchange for disclosing my child's Information to Sobi and providing Program services.

I understand that I do not have to sign this Authorization. A decision by me not to sign this Authorization will not affect my child's ability to obtain medical treatment from healthcare providers, payment for treatment or eligibility for health insurance benefits, or access to Sobi medications. However, if I do not sign this Authorization, I understand my child will not be able to participate in the Program.

I understand that this Authorization expires ten years from the date signed below, or earlier if required by state or local law, unless and until I cancel (take back) this Authorization before then. I may change my mind and cancel this Authorization at any time by calling 1-833-SYNAGIS (1-833-796-2447) or by notifying Sobi in writing at SYNAGIS CONNECT, PO Box 29076, Phoenix, AZ 85038-9076. Cancellation of this Authorization will end further uses and disclosures of my child's Information by my child's healthcare provider and staff, pharmacies, and health insurers based on this Authorization, and my child's participation in the Program when they receive notice of my cancellation, but will not affect any uses or disclosure of my child's Information made by my child's healthcare providers and staff, pharmacies, and health insurers based on this Authorization before receipt of the cancellation.

Full name (printed) of parent/caregiver: _____

SIGN HERE Parent/Caregiver Signature _____ Date _____

CONSENT FOR ENROLLMENT IN SYNAGIS CONNECT™:

By signing below, I am enrolling in SYNAGIS CONNECT™ (the "Program"). I authorize Sobi, Inc., and its affiliates, business partners, vendors, and other agents (collectively, "business partners" and together with Sobi, Inc., "Sobi") to provide me and my child with services for which we are eligible under the Program. Such services may include medication and adherence communications and support, medication dispensing support, insurance coverage and financial assistance support, disease and medication education, and other support services offered now or in the future. As part of the Program offerings, I agree to enrollment in the copay assistance program if I am eligible.

- I also consent to receive autodialed and prerecorded marketing calls and text messages from Sobi, and companies working with Sobi, at the telephone number(s) that I provide. I understand that my consent is not required as a condition of purchasing or receiving any goods or services from Sobi. I understand that I may revoke this Authorization and choose not to receive automated marketing calls and text messages from Sobi at any time by calling 1-833-SYNAGIS (1-833-796-2447) or by notifying Sobi in writing at PO Box 29076, Phoenix, AZ 85038-9076.

Full name (printed) of parent/caregiver: _____

SIGN HERE Parent/Caregiver Signature _____ Date _____

