SYNAGIS CONNECT®

Universal Enrollment and Prescription Form

Call SYNAGIS CONNECT at **1-833-SYNAGIS (1-833-796-2447)** Monday through Friday 8 am to 8 pm ET, for assistance or visit **SYNAGISHCP.com**.

Healthcare providers please complete this form, have the patient sign the indicated area on page 2 and fax it to SYNAGIS CONNECT at **1-800-201-4938.**

Provider Preference: ◯ **Buy-and-bill** ◯ **Preferred Specialty Pharmacy** _____

1 PATIENT AND CAREGIVER INFORMATION

***Asterisk indicates required field.**

PATIENT INFORMATION

◯ Please indicate if multiple births.

Last Name*: _____ First Name*: _____ Middle Initial: _____

Date of Birth*: ____/____/____ Sex: ◯ Male ◯ Female

Patient weight information is collected in the prescription section.

PARENT/CAREGIVER INFORMATION

Last Name*: _____ First Name*: _____ Middle Initial: _____

Street*: _____ Unit: _____ City*: _____ State*: _____ ZIP Code*: _____

Home Phone*: _____ Mobile Phone*: _____

Email: _____ Preferred Contact Method: ◯ Phone ◯ Email

Best time to call: ◯ Morning ◯ Afternoon ◯ Evening Preferred Language: _____

◯ I authorize **SYNAGIS CONNECT** to leave a detailed message, including the name of my child's prescription, SYNAGIS® (palivizumab).

2 INSURANCE INFORMATION

Please provide a copy of all medical and prescription cards (front and back).

	Primary Medical Insurance	Secondary Medical Insurance	Prescription Insurance
Insurance Name*			
Phone*			
Policy ID #*			
Group #*			
Policyholder Name*			
Relationship to Patient			
Policyholder DOB			
BIN #*			
PCN #*			

◯ No Insurance

3 PRESCRIBER INFORMATION

***Asterisk indicates required field.**

Last Name*: _____ First Name*: _____

Office/Institution Name: _____

Street: _____ Suite: _____ City: _____ State: _____ ZIP Code*: _____

NPI #*: _____ Tax ID #: _____ Medicaid Provider ID #: _____

Office Contact Name: _____ Phone*: _____

Fax*: _____ Office Contact Email: _____

4 PRESCRIBER CERTIFICATION STATEMENT

***Required signature and date.**

I hereby attest that I am the prescribing healthcare provider and I agree to submit requests to SYNAGIS CONNECT® because I have determined that SYNAGIS® (palivizumab) is medically appropriate, and I have explained such to my patient's parent or caregiver. I certify that I have received the necessary authorization to release the above-referenced information and other protected health information (as defined by the Health Insurance Portability and Accountability Act [HIPAA] of 1996) to Service Providers for the purpose of providing my patient with access and reimbursement assistance for SYNAGIS, assisting in initiating or continuing therapy, and/or the evaluation of the patient's eligibility for support. I authorize the Service Providers, as my designated agent and on behalf of my patient, to forward a prescription for SYNAGIS, by fax, electronic transmission, or other appropriate means under applicable law, to an appropriate pharmacy that dispenses SYNAGIS. I also certify that this prescription complies with all applicable state and local laws. I agree to notify the Service Providers if I become aware at any time in the future of changes in my patient's circumstance that would affect their eligibility, including, but not limited to, changes in health insurance status or coverage, financial status, or United States residency status. 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. Furthermore, I will not seek reimbursement from any third-party payer or government entity for any product that may be provided free of charge through a support program offered by SYNAGIS CONNECT. I acknowledge I may be contacted by email, postal mail, or fax using the information I've provided, and I understand my personal information will be used and disclosed by SYNAGIS CONNECT in accordance with Sobi's privacy policy, available at https://sobi-northamerica.com/privacy-policy.

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*** ____ / ____ / ____

SYNAGIS CONNECT®

Universal Enrollment and Prescription Form

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

5 CLINICAL INFORMATION

*Asterisk indicates required field.

Birth Weight*:
_____kg
Current Weight*:
_____kg
Date of Weight*:
____ /____ /____

◯ Prematurity:
_____ weeks/days GA (eg, 32.3)
ICD-10: _

◯ Bronchopulmonary dysplasia/chronic lung disease
◯ Age <12 months ◯ Age 12 months to <24 months
Supplemental oxygen (dates): _____
Chronic corticosteroids (drugs/dates): _____
Diuretic therapy (drug/dates): _____
Bronchodilators (drugs/dates): _____
ICD-10: _____

◯ Hemodynamically significant congenital heart disease
◯ Age <12 months
◯ Age 12 months to <24 months
ICD-10: _____
◯ Other conditions:
Description: _____
Diagnosis: _____
ICD-10: _____

NICU/Hospital dose administered: ◯ No ◯ Yes Date(s): _____ Expected date of first/next injection ___/___/_
Current medications: _____
Known allergies: _____
SP directions to dispense: ◯ Office/Clinic ◯ Patient's Home ◯ Other _____
Prescriber Requests Home Health Agency Services For Injection Administration ◯ No ◯ Yes
Preferred Home Health Agency _____

6 PRESCRIPTION INFORMATION

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: _____
◯ OPTIONAL: Epinephrine	1:1000 amp	Inject 0.01 mg/kg SC as directed for anaphylaxis	Quantity: _____	Refills: _____

◯ Ancillary supplies (needles, syringes, sharps for purposes of administration)

Stamp Signature Not Allowed

SIGN HERE **Prescriber Signature** _____ **Date** ____ /____ /____
Dispense as Written

OR

SIGN HERE **Prescriber Signature** _____ **Date** ____ /____ /____
Substitution Permitted

7 PATIENT AUTHORIZATION

My signature below certifies that I have read, understand, and agree to the Patient Authorization Statement in section 8.

SIGN HERE **Parent/Authorized Representative Signature** _____ **Date** ____ /____ / ____
I am the parent/legal guardian, or I affirm I am the authorized representative of the patient and have a valid power of attorney to act on their behalf.

8 SYNAGIS CONNECT PATIENT AUTHORIZATION STATEMENT

My signature below on this enrollment form authorizes my child's doctor(s), healthcare providers, health plan or payer, and pharmacy to disclose to Sobi Inc. ("Company") and its third party suppliers, vendors, and other service providers supporting SYNAGIS CONNECT® (collectively, the "Service Providers") information about my child including my child's medical condition and treatment, health insurance and coverage claims, and prescriptions (together, "Protected Health Information and/or Personally Identifiable Information"). This information can include spoken or written facts about my child's health and insurance benefits. It can include copies of records from my child's healthcare providers or health plans about my child's health or healthcare. I understand that my child's healthcare providers and my child's pharmacy may receive remuneration, or payment, for disclosing my child's information pursuant to this Authorization.

I understand that Service Providers may be compensated by Sobi. The Service Providers will use, redisclose and give out my child's information to (i) assist in my child's enrollment in SYNAGIS CONNECT and to contact me and/or the person legally authorized to sign on my child's behalf; (ii) provide me and/or the person legally authorized to sign on my behalf with educational material and other information materials related to the SYNAGIS CONNECT offerings; (iii) verify, investigate, assist with, and coordinate my child's coverage for SYNAGIS® (palivizumab) with my child's payer; (iv) coordinate prescription fulfillment; (v) assess my child's eligibility for patient assistance and/or benefits if necessary and applicable; and (vi) assist with analyses of the efficiencies and performance of services provided by Service Providers. In some instances, the Service Providers may de-identify my child's information and use or disclose the de-identified information (in individual or aggregated form) for any legitimate business purposes. I understand that the Service Providers will make reasonable efforts to keep my child's information private; however, I understand that once my child's information has been disclosed to the Service Providers, how the Service Providers further disclose my child's information may no longer be protected under federal and state privacy laws.

This Authorization will last for three (3) years from the date of my signature or until I am no longer receiving SYNAGIS or enrolled in SYNAGIS CONNECT, whichever is later, unless a shorter period is mandated by state law. MARYLAND HEALTHCARE PROVIDERS, under Md. Code HG § 4-303(b)(4) this authorization expires ONE YEAR from the date of signature. I understand that I do not have to sign this authorization, but if I do not, my child will not be able to have their insurance coverage verified, have alternate sources of assistance researched, or access other support provided by or on behalf of SYNAGIS CONNECT. My choice as to whether to sign this form will not change the way my child's doctors, healthcare providers, or payers treat my child.

I have the right to revoke or cancel this Authorization, in writing, at any time by providing written notice to my healthcare providers and/or the administrators of SYNAGIS CONNECT at PO Box 1989, Columbus, OH 43216 or I can cancel this Authorization at any time by calling SYNAGIS CONNECT at 1-833-SYNAGIS (1-833-796-2447). If I chose to cancel my child's participation in SYNAGIS CONNECT it means that I no longer want them to share any more information with the Service Providers, but it will not change any actions that took place before I told them. Cancellation of this Authorization will be valid when received by the administrators of SYNAGIS CONNECT. I understand that a cancellation is not effective to the extent that any person or entity has already acted in reliance on my authorization. I know I have a right to see or request a copy of the information my child's healthcare providers or payers have given to the Service Providers. If I receive services offered under SYNAGIS CONNECT, I agree to allow Company and Service Providers to contact me via email or cell phone using the contact information provided in this enrollment form.

sobi rare strength