SYNAGIS CONNECT™

Universal Enrollment and Prescription Form

SYNAGIS® PALIVIZUMAB

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.

○ Prematurity: ______ weeks'/days' GA

ICD-10: ____________

○ Other conditions:

Description: ____________

Diagnosis: ____________

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: ____________

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

○ Ancillary supplies

Stamp Signature Not Allowed

Prescriber Signature ____________ **Date** ______

Dispense as Written

OR

Prescriber Signature ____________ **Date** ______

Substitution Permitted

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** ______

PARENT/CAREGIVER CONSENT CONTINUED ON NEXT PAGE

Not Required for Submission

SYNAGIS CONNECT™

SYNAGIS® PALIVIZUMAB

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**____________________

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