



RSV Prophylaxis Enrollment Form

Fax completed form to CuraScript at 1-866-862-3170. For Provider Services, call 1-888-662-0944.

Part I Patient Information (double click on the fields below to fill in this form electronically)

Form section for Part I Patient Information, including fields for Patient's last name, First name, Middle initial, Address, City, State, ZIP code, Day phone no., Night phone no., Date of birth, Parent/Guardian, Allergies, Sex, Primary insurance, Secondary insurance, Cardholder name, Member ID and Group no., BIN#, Insurance phone no., and Employer.

Part II Physician Information (please supply copy of patient's insurance card)

Form section for Part II Physician Information, including fields for Prescriber's name, Hospital/Clinic, Office contact name, Address, City, State, ZIP code, Phone no., Fax no., DEA no., NPI no., and UPIN.

Part III Medical Criteria (double click on the fields below to fill in this form electronically)

Form section for Part III Medical Criteria, containing sections 1. PATIENT WEIGHT AND GESTATIONAL AGE, 2. PRIMARY DIAGNOSIS, 3. CLINICAL INFORMATION, and 4. INJECTION HISTORY, with various checkboxes and text input fields.

Part IV Prescription (double click on the fields below to fill in this form electronically)

Form section for Part IV Prescription, including sections 1. MEDICATION and 2. SUPPLIES, with checkboxes for medication types and supplies, and fields for signature, date, and shipping information.

*Confidentiality notice: This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above.