

MedImmune Assistance Program

MedImmune is proud to offer the MedImmune Assistance Program (MAP), designed to provide temporary assistance to individuals who need access to Synagis® (palivizumab), but who lack health insurance. The program can be reached by calling 1(877) 480-8082. By calling this number, a healthcare provider can review the patient's eligibility with a program specialist. In order to qualify for assistance, a patient must:

- be receiving Synagis for its FDA-approved indication,
- have no form of health insurance (including Medicare, Medicaid, or any other sponsored coverage); and,
- meet the income/asset/expense parameters of the program.

A final eligibility determination will be made upon the program's receipt of application materials.

If the patient is eligible, providers will receive product to be used for the treatment of the qualified patient.

If a patient is not eligible for assistance, all efforts will be made by program staff to direct the patient towards insurance programs or other funding sources that may be able to provide assistance.

Important Safety Information

Synagis® (palivizumab) is indicated for the prevention of serious lower respiratory tract disease caused by respiratory syncytial virus (RSV) in pediatric patients at high risk of RSV disease and is administered by intramuscular injection. Safety and efficacy were established in infants with bronchopulmonary dysplasia (BPD), infants with a history of premature birth (<35 weeks gestational age), and children with hemodynamically significant congenital heart disease (CHD). Synagis has been used in more than one million children in the U.S. since its introduction in 1998. The first dose of Synagis should be administered prior to commencement of the RSV season. Patients, including those who develop an RSV infection, should continue to receive monthly doses throughout the season.

Very rare cases (<1 per 100,000 patients) of anaphylaxis and rare (<1 per 1,000 patients) hypersensitivity reactions have been reported with Synagis. Cases of anaphylaxis were reported following re-exposure to Synagis and rare severe hypersensitivity reactions occurred on initial exposure or re-exposure. If a severe hypersensitivity reaction occurs, therapy with Synagis should be permanently discontinued. If milder hypersensitivity reaction occurs, caution should be used on re-administration of Synagis.

In clinical trials, the most common adverse events occurring at least 1% more frequently in Synagis-treated patients than controls were upper respiratory infection, otitis media, fever, and rhinitis. Cyanosis and arrhythmia were seen in children with CHD.

MedImmune Assistance Program Patient Application

Patient Information

Please see enclosed full prescribing information

SYN07-024

Patient Last Name	Patient First Name	Patient MI	Date of Birth
Parent/ Guardian First and Last Name		Address	
City	State	Zip	
Home Phone	Work Phone	Cell Phone	

Check all that apply:

	Has Benefits	Application Pending	Not Eligible	Has Not Applied
Medicaid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other State Medical Assistance (CHIP, Title V, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Private Insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is this patient a U.S. Resident? Yes No

Primary Diagnosis (ICD-9-CM diagnosis codes are in parenthesis)

Patient's Gestational Age (GA) _____ Birth Weight _____ kg/lbs

Current Weight _____ kg/lbs Date Recorded _____

Congenital Heart Disease (745.0-747.9) 29-30 weeks' GA (765.25)

Chronic Respiratory Disease Arising in the Perinatal Period (CLD) (770.7) 31-32 weeks' GA (765.26)

< 24 weeks' GA (765.21-765.22) 33-34 weeks' GA (765.27)

25-26 weeks' GA (765.23) 35-36 weeks' GA (765.28)

27-28 weeks' GA (765.24) 37 or more weeks' GA (765.29)

Other Respiratory Conditions of Fetus and Newborn (770.0-770.9)

Congenital Anomalies of Respiratory System (748)

Other _____ Secondary diagnosis (if applicable) _____

Financial Information

Gross Monthly Household Revenue Sources

List # in household: _____
(Applicant & Dependents)

All Salary/Wages/Pension \$ _____

Interest/Dividends/Annuities \$ _____

Unemployment Compensation \$ _____

Social Security/Supplement/Disability \$ _____

Income _____

Other (Alimony, Capital Gains, Child Support, etc.) \$ _____

Total monthly household out-of-pocket medical expenses \$ _____

Household Cash Assets

Cash/Savings/Checking/Money Market \$ _____

CD's \$ _____

Stock/Bonds \$ _____

Total Household Cash Assets \$ _____

MEDICAL CRITERIA

1. Diagnosis of chronic pulmonary disease (CLD/BPD) and less than 24 months of age? Yes No
 Has patient received or is currently on medical treatment (check all that apply and provide last date received):
 Oxygen Date _____ Corticosteroids Date _____
 Bronchodilators Date _____ Diuretics Date _____

2. Diagnosis of hemodynamically significant congenital heart disease and less than 24 months of age? Yes No
 Patient has following condition: Diagnosis of moderate-severe pulmonary hypertension
 Medications for CHD _____ Last Date Received _____

3. Prematurity:
 Gestational age of ≤ 28 weeks and ≤ 12 months of age at the start of RSV season
 Gestational age of 29-32 weeks and < 6 months of age at start of the RSV season
 Gestational age of 33-35 weeks and < 6 months of age at start of the RSV season

Clinically has the following risk factors (check all that apply):

<input type="checkbox"/> School Age Siblings	<input type="checkbox"/> Birth Weight Less Than 2500 g
<input type="checkbox"/> Exposure to Environmental Air Pollutants	<input type="checkbox"/> Crowded Living Conditions
<input type="checkbox"/> Daycare	<input type="checkbox"/> Multiple Birth
<input type="checkbox"/> Severe Neuromuscular Disease	<input type="checkbox"/> Family History of Asthma
<input type="checkbox"/> Congenital Abnormality of Airway	
<input type="checkbox"/> Other Medical History: _____	

Prescription Information

Synagis® (palivizumab)
 Sig: Inject 15mg/kg IM one time per month

Monthly Quantity: _____ 100 mg vials _____ 50 mg vials
 _____ Refill _____ months

Other: _____

Provider Information

Physician Name (Include professional designation)	State License or DEA Number		
Clinic or Hospital	Tax ID		
Address	City	State	Zip
Contact Name	Office Phone	Office Fax	

*Please note that the **Physician Certification and Request** and the **Patient Authorization and Certification** are included on the following page of the application form. The MedImmune Assistance Program will not be able to continue to process the application without these signed documents.*

Physician Certification and Request

I request on behalf of my patient the MedImmune product, Synagis® (palivizumab), and do so because my patient does not have insurance coverage. I certify that I am currently licensed to prescribe and receive medications and that the information provided by me herein is accurate and complete. I understand that the patient's eligibility under this program is subject to approval under the program guidelines, including meeting financial criteria, and that MedImmune reserves the right to change or terminate this program without prior notice. I understand that the assistance provided to the patient is temporary and the patient may be asked to reapply at designated intervals. I certify that, to the best of my knowledge, my patient has no access to medication benefit assistance, Medicare, Medicaid, government subsidized clinics, other government or private programs, or any other help to purchase medication. I attest to my patient's financial need and I certify that, to the best of my knowledge, my patient does not have the ability to pay for the Synagis injection to be administered. I certify that I have not received reimbursement for the Synagis being requested or previously administered. I understand that if the patient's income or insurance status changes, the patient may no longer be eligible under this program. I certify that no free vials provided under this program will be distributed for sale to any individual or organization and that I will not seek payment or reimbursement from the patient or any third-party payer. I certify that my patient is a resident of the US. I agree to immediately notify a program representative if the patient's insurance or income status changes. I understand that I am under no obligation to prescribe any MedImmune drug to participate in this program and that I have not received, nor will receive any benefit from MedImmune or the Lash Group for prescribing a MedImmune drug. I understand that the Lash Group and MedImmune are not responsible for filing any insurance claims. **I agree to abide by this certification throughout my participation in the program and to notify a program representative if aspects of this certification are no longer applicable.**

Original Signature of Physician

Date

The patient or the patient's parent or guardian must sign both the certification and the authorization below in order to be eligible to participate in the Patient Assistance Program.

Patient Certification

I attest that the information supplied by me herein is complete and accurate. I understand that the patient's eligibility under this program is subject to approval under the program guidelines, and that MedImmune reserves the right to change or terminate the program without prior notice. I understand that this assistance is temporary and that I may be asked to reapply at designated intervals. I certify that the patient has no access to Medicare, Medicaid, government subsidized clinics, other government or private programs, or any other help to purchase the patient's medication. I certify that I do not have the ability to pay for the MedImmune product administered. I agree to inform my physician and/or program representative immediately if my income or insurance status changes. I understand that MedImmune and the consultants that are helping MedImmune administer this program are not responsible for filing any insurance claims. I agree to abide by this certification throughout my participation in the program and to notify a program representative if aspects of my certification are no longer applicable.

Signature of Parent of Legal Guardian

Date

Patient Authorization to Use and Disclose Medical Information

By signing below, I also authorize the patient's doctor, health plan or other healthcare provider to release the patient's medical and insurance status information to MedImmune and its consultants for the sole purpose of assessing my eligibility for participation in the program and administering the program. I further authorize MedImmune and its consultants to re-disclose that information, and information in this application, to health insurance companies and other potential sources of funding for Synagis. I understand that this authorization will expire twelve (12) months from the date of signing it. I may revoke this authorization at any time by writing to the patient's doctor, except that information that has been disclosed before the patient's doctor receives my revocation will not be retrieved. I understand that I may receive a copy of this authorization upon request.

I understand the patient's doctor will treat the patient even if I do not sign this authorization. However, I understand that the patient cannot participate in the MedImmune Assistance Program if I do not sign this authorization, or if I revoke the authorization. I understand that once

the patient's health information has been disclosed in reliance on this authorization, the information may no longer be protected under federal privacy laws, and may be re-disclosed.

Signature of Legal Guardian

Date

Relationship to Patient