ACCESS 360™ FAX COVER SHEET

For support with your referral, please contact Access 360: Phone: 1-877-778-9010, Fax: 1-866-252-1749.
For coding resources, please refer online: www.MyAccess360.com

IN REFERENCE TO:

Required ★

Patient Name: ____

Prescriber Name: ____________________ Prescriber Phone: ____________________ Prescriber Fax: ____________________

IF YOU KNOW WHICH SPECIALTY PHARMACY PROVIDER (SPP) TO SEND YOUR REFERRAL TO:

1. Fax your referral directly to the SPP of your choice
   SPP Name: ____________________ Telephone: ____________________ Fax: ____________________

Required ★

IF YOU NEED SUPPORT FROM ACCESS 360, FAX ALL OF THE FOLLOWING TO 1-866-252-1749:

1. Completed Fax Cover Sheet
2. A Statement of Medical Necessity (SMN/Referral) signed and dated by the prescriber
3. A signed/dated Access 360 Patient Authorization Form

SUPPORT NEEDED FROM ACCESS 360 (CHECK ALL REQUESTED SUPPORT):

Comments: ____

____

Required: Access 360 Patient Authorization Form and signed/dated Referral/SMN

☐ **Submit Referral/SMN to the following (Provider's SPP choice is required for submission):**
SPP Name: ____________________ **Telephone:** ____________________ **Fax:** ____________________

☐ **SPP Research:** I don't know which SPP; please research

☐ **SMN/Referral Follow-Up:** Follow up with SPP to confirm shipment

☐ **Benefit Investigation:** Identify patient-specific coverage, SPPs, out-of-pocket costs, and authorization requirements for Synagis®

☐ **Benefit Investigation Re-Verification**

☐ **Prior Authorization (PA) Research:** I don't know insurance approval requirements; please research

☐ **Prior Authorization Submission Assistance and Follow-Up:** Assist in PA submission and/or follow up

☐ **Appeal Support:** Help me understand appeal options and payer-specific documentation/process

☐ **Copay Assistance:** My patient is insured but needs financial assistance

☐ **MedImmune Assistance Program (MAP):** My patient is uninsured or rendered uninsured and would like to apply to receive Synagis at no cost

The following are required to apply for MAP:

- *A complete **MAP application**, signed and dated by parent/caregiver and prescriber.*
- *A complete, signed, and dated **Access 360 Patient Authorization Form**.*
- *A complete, signed, and dated **Statement of Medical Necessity (SMN)**.*
- *Documentation of household income, submitted within 21 days of application submission (see **MAP application** for details).*
- *Documentation of a denied appeal to the applicant's insurance company for Synagis coverage. Please also include documentation of the submitted appeal (applies to rendered uninsured applicants only).*

☐ **Register Only** (to view my patient's records in the Access 360 Provider Portal)

☐ **Transcription** (no clinical or prescription information can be transcribed)

☐ **I give MedImmune permission to contact this patient to help obtain a signed Access 360 Patient Authorization Form**

I hereby authorize the Access 360 program to convey the attached prescription on my behalf to the pharmacy chosen by or for the Patient, and receive information on the status and related matters. By signing below, I certify that a) Synagis is medically necessary; b) I have received the necessary authorization to release the information included on this form and the attached SMN and other protected health information (as defined by HIPAA) to MedImmune Access 360 and contracted dispensing pharmacy or other entities for the purpose of seeking reimbursement, assisting in initiating or continuing therapy and/or the evaluation of the patient's eligibility for MedImmune Assistance Program related to MedImmune products, as a break in treatment would negatively impact the patients therapeutic outcome; and c) I allow MedImmune Access 360 to convey, on my behalf, to the pharmacy chosen by the above-named patient, the prescription described herein.

Required ★

Prescriber or Prescriber's Designee (required if Access 360 support requested)

Print Name: ____________________ **Signature:** ____________________ **Date:** ____________________

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