PATIENT AUTHORIZATION FORM (PAF)
MEDIMMUNE ACCESS 360™ AND CRADLE WITH CARE℠

Patient's name _____ Patient's insurance carrier _____

Birth date _____ Birth weight _____lb _____oz Medical record # (optional) _____

Parent/caregiver information _____
(Name) (Mobile phone) (Email)

Parent/caregiver address _____
(Street) (Apt) (City) (State) (Zip)

Pediatrician/specialist _____
(Name) (Practice Name) (Phone) (Fax)

Pediatrician/specialist's address _____
(Street) (Suite) (City) (State) (Zip)

High-risk infant:

❍ (Prematurity) Born at _____ GA (weeks/days)
Risk factors/other _____

❍ Bronchopulmonary dysplasia/chronic lung disease of prematurity (BPD/CLDP)

❍ Hemodynamically significant congenital heart disease (CHD)

Dosing assessment/schedule:

❍ Patient received initial dose in hospital Date _____

❍ Date of next dose _____

Select Safety Information

Common side effects of Synagis® (palivizumab) include fever and rash. Other possible side effects include skin reactions around the area where the shot was given (like redness, swelling, warmth, or discomfort).

Please see Important Safety Information on next page.

MedImmune Access 360™ Patient Authorization

By signing below, I agree to the use and disclosure of the patient's PHI and who may see it for the purposes described in the "MedImmune Access 360" section of the previous page. If I cancel this Authorization, the Healthcare Providers and Insurers are prohibited from further disclosing the patient's PHI to MedImmune, including its contractors and affiliates; however, it will not impact MedImmune's ability to use and disclose PHI already received prior to the receipt of the revocation. If I refuse to sign this Authorization, or revoke it later, the patient will not be able to receive assistance from MedImmune Access 360 Programs. I may revoke (cancel) this Authorization at any time in writing by mailing a letter to P.O. Box 5758, Louisville, KY 40255-0758 or calling Access 360 at 1-877-778-9010. Once the recipient receives the patient's PHI, it may be redisclosed by the recipient and may no longer be protected by federal privacy laws.

Signature of Parent/Caregiver _____ Date _____

This authorization expires two (2) years from the date I sign this form unless a shorter period is required by state law.

Cradle with Care℠

By signing below, I am allowing the Hospital and my child's healthcare providers to give my child's information to MedImmune and its contractors for the purposes described in the "Cradle with Care" section on the previous page. At any time, I can change my mind and decide I no longer want my child's doctors to give my child's information to MedImmune or its contractors. I may revoke (cancel) this Authorization at any time in writing by mailing a letter to P.O. Box 5758, Louisville, KY 40255-0758 or faxing it to 1-866-252-1749. However, if my child's information was already given to MedImmune before a letter was received, then my child's doctors/Hospital will not ask MedImmune to give this information back. I understand that the Cradle with Care program can send me text messages if I provide my mobile number above and that text messaging rates may apply.

Signature of Parent/Caregiver _____ Date _____

This authorization expires two (2) years from the date I sign this form unless a shorter period is required by state law.

PEDIATRICIAN/SPECIALIST COPY