Synagis respiratory syncytial virus (RSV) enrollment form

Today's date: _____ **Need by date:** _____

Complete this form for UnitedHealthcare Community Plan members needing a Synagis® prescription and fax it to the Pharmacy Prior Authorization department at **866-940-7328**. We'll notify you and your patient who is a member of the prescription coverage. This form helps ensure the member's medical condition meets the clinical drug guidelines. Any missing information may cause a delay in the coverage decision.

If you have questions, call the Pharmacy Prior Authorization department at **800-310-6826**.

Member information (Please complete the following or send member demographic sheet.)

Member name: Member ID number:

Parent/guardian name: Home phone:

Address: Alternate phone:

City, State, ZIP: Date of birth (mm/dd/yyyy): Sex: ☐ M ☐ F

Medical information (Attach medical records, hospital discharge summary or other evidence that support each diagnosis.)

ICD-10 code: Diagnosis description:

Clinical

Member gestational age (required): _____weeks _____days Is member from a multiple birth? ☐ Yes ☐ No _____

Current weight in: _____kilograms _____pounds Date recorded: _____

Chronic lung disease (CLD): ☐ Yes ☐ No ICD-10 code: _____ (attach medical history)

Requires more than 21% oxygen at least 28 days after birth? ☐ Yes ☐ No

Therapy received within 6 months start of RSV season (check all that apply):

☐ Supplemental oxygen used: Last date:

☐ Chronic systemic corticosteroid therapy used: Last date: Drug name:

☐ Diuretics therapy used: Last date: Drug name:

Congenital heart disease ☐ Yes ☐ No ICD-10 code: (If yes, attach medical history)

Is there acyanotic heart disease? ☐ Yes ☐ No

Is there cyanotic heart disease? ☐ Yes ☐ No Is there moderate to severe pulmonary hypertension? ☐ Yes ☐ No

Does member require cardiac surgical procedure? ☐ Yes ☐ No

Was there a consultation with a pediatric cardiologist during the member's first year of life? ☐ Yes ☐ No

United Healthcare Community Plan

Member ID number: Member name: Member DOB:

Clinical (cont.)

List of cardiac medications:

Last date received:

Last date received:

Is there compromised handling of respiratory secretions? ☐ Yes ☐ No (If yes, attach medical history) ICD-10 code:

Is there congenital abnormality of the lower airway? ☐ Yes ☐ No (If yes, attach medical history) ICD-10 code:

Does member have a neuromuscular condition? ☐ Yes ☐ No (If yes, attach medical history) ICD-10 code:

Is member receiving chemotherapy? ☐ Yes ☐ No (If yes, attach medical history) ICD-10 code:

Does member have cystic fibrosis? ☐ Yes ☐ No (If yes, attach medical history) ICD-10 code:

Was there hospitalization for pulmonary exacerbation in first year of life? ☐ Yes ☐ No (If yes, attach medical history)

Prescription information

Medication	Strength	Directions	Quantity	Total doses requested
Rx Synagis® (palivizumab)	50 and/or 100mg vials	Inject 15mg/kg IM 1 time per month	Other: QS to achieve 15mg/kg	
Rx Epinephrine	1:1000 amp	Inject 0.01 mg/kg subcutaneously as directed for anaphylaxis	QS	

Were previous injections given (including doses given in hospital)? ☐ Yes ☐ No (If yes, please list dates)

Which months are requested for the season? ☐ Nov. ☐ Dec. ☐ Jan. ☐ Feb. ☐ March ☐ Other (specify)

Is specialty pharmacy going to coordinate injection training/home health nurse visits as necessary? ☐ Yes ☐ No

Does member have allergies? ☐ Yes ☐ No (If yes, please list):

List other medical history:

Has the child been previously approved for Synagis by another insurance carrier for the season? ☐ Yes ☐ No
(If yes, attach approval from previous insurance carrier and clinical notes for doses already given.)
Upon request, ancillary supplies will be provided without charge, as needed for administration.

Prescriber information

Prescriber name: Phone: Fax:

Address: Drug Enforcement Administration (DEA) registration number:

Suite: National Provider Identifier (NPI) number:

City State: ZIP:

Contact person: Phone:

Prescriber signature: Date:

Insurance information (Please fill out completely and fax a copy of both sides of the member's insurance card along with this form.)

Primary: Name of insurer: Phone:

Subscriber name: ID number:

Secondary: Name of insurer: Phone:

Subscriber name: ID number:

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