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 UnitedHealthcare Community Plan 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 to 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 UnitedHealthcare Community Plan 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: □ Male □ Female

Medical Information (Attach medical records, hospital discharge summary or other evidence that supports each diagnosis.)	
ICD-10 Code:	Diagnosis Description:

Clinical

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

Current weight in: _____kilograms _____pounds Date recorded: _____

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

Require more than 21% oxygen at least 28 days after birth? □ Yes □ No

Therapy received within six 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

List cardiac medications:

_____Last date received:_____

_____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: _____

Member ID Number:_____Member Name:_____Member DOB:____/____/____

Clinical (continued)

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 one time per month	Other: QS to achieve15mg/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? (Circle) Nov. Dec. Jan. Feb. Mar. Other (specify) _____

Is specialty pharmacy going to coordinate injection training/home health nurse visit 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 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

Primary: Name of Insurer:_____ Subscriber Name:_____ ID Number:_____	Phone
Secondary: Name of Insurer:_____ Subscriber Name:_____ ID Number:_____	Phone

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