

Synagis® Respiratory Syncytial Virus (RSV) Enrollment Form

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

Please complete this entire 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 will notify you and your patient of the prescription coverage. This form helps to ensure the patient's medical condition meets the clinical drug guidelines. Any missing information may cause a delay in the coverage decision.

If you have questions, please call the UnitedHealthcare Community Plan Prior Authorization Department at **800-310-6826**.

Member Information (Please complete the following or send patient 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: <input type="checkbox"/> Male <input type="checkbox"/> Female

Medical Information (Please attach medical records, hospital discharge summary or other evidence that supports each

ICD-10 Code: _____ Diagnosis Description: _____

Clinical

Patient's gestational age (required): _____ weeks _____ days Is patient 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)

Require more than 21 percent 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: _____ (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 patient require cardiac surgical procedure? Yes No

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

Please 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 patient have a neuromuscular condition? Yes No

(If Yes, attach medical history.) ICD-10 code: _____

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

Clinical (continued)

Is patient receiving chemotherapy? Yes No (If Yes, attach medical history.) ICD-10 code: _____

Does patient 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 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? (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 patient 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, please 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 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 patient'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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