



### Synagis® Respiratory Syncytial Virus (RSV) Enrollment Form

Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Need by date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please 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: <input type="checkbox"/> Male <input type="checkbox"/> Female

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

ICD-10 Code:	Diagnosis Description:
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#### 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)  
 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 a cyanotic 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: \_\_\_\_\_

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 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  NoDoes 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, 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 (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

<b>Primary:</b> Name of Insurer: _____	Phone
Subscriber Name: _____ ID Number: _____	
<b>Secondary:</b> Name of Insurer: _____	Phone
Subscriber Name: _____ ID Number: _____	

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