

Synagis Request Form

- Drug will be dispensed from a pharmacy (pharmacy benefit) → **FAX 866-399-0929** Phone: 866-399-0928
- Drug will be dispensed from provider office, hospital, outpatient stock (Buy and bill/medical benefit) → **FAX 888-453-4756** Phone: 877-644-4623

I. MEMBER INFORMATION

Patient Name: _____
 ID Number: _____
 Date of Birth: _____
 Sex: Male Female
 Address: _____
 City, State, Zip: _____
 Primary Phone: _____
 Alternative Phone: _____
 Medication Allergies: _____

II. PRESCRIBER INFORMATION

Prescriber Name: _____
 Specialty: _____
 NPI or DEA Number: _____
 Group or Hospital: _____
 Address: _____
 City, State, Zip: _____
 Phone: _____
 Fax: _____
 Office Contact Name: _____

III. INSURANCE INFORMATION (Complete or Attach Copies of cards)

Primary Insurance: _____ Secondary Insurance: _____
 ID Number: _____ ID Number: _____
 Phone: _____ Phone: _____

IV. CLINICAL INFORMATION

*** Please submit supporting clinical information ***

Patient Demographics:

Gestational Age at Birth: _____ weeks _____ days Primary Diagnosis: _____ (Please provide ICD-10: _____)
 Was this season's first Synagis dose given in the NICU? yes no If yes, provide date(s): _____ Expected date of first/next injection: _____

Patient Evaluation (Check all that apply & submit clinical documentation):

- Diagnosis of **Chronic Lung Pulmonary Disease* (CLD)** and **less than 12 months** of age at start of RSV Season Please provide ICD-10: _____
 * CLD is generally defined as: gestational age <32 weeks, 0 days and a requirement for >21% oxygen for at least the first 28 days after birth.
 CLD is NOT defined as asthma, croup, recurrent upper respiratory infections, chronic bronchitis, bronchiolitis, or a history of a previous RSV infection
- Diagnosis of **Chronic Lung Pulmonary Disease* (CLD)** and **less than 24 months** of age at start of RSV Season Please provide ICD-10: _____
 Is patient currently receiving treatment of the following? (check all that apply and provide last date received):
 Oxygen, Date: _____ Corticosteroids, Date: _____ Diuretics, Date: _____ Bronchodilator, Date: _____
- Diagnosis of hemodynamically significant **Congenital Heart Disease (CHD)** and **less than 12 months** of age at start of RSV Season ICD-10: _____
 Patient has the following conditions (Check all that apply): Moderate-Severe Pulmonary Hypertension Cyanotic Heart Disease
 Acyanotic Heart Disease and receiving medications to control CHF (list): _____ Last Date Received: _____
- Cystic Fibrosis (CF)** and **less than 12 months** of age at start of RSV Season Please provide ICD-10: _____
 Patient has the following conditions (Check all that apply): CLD
 Nutritionally Compromised; Receiving nutritional supplementation? (list): _____
- Cystic Fibrosis (CF)** and **less than 24 months** of age at start of RSV Season Please provide ICD-10: _____
 Patient has the following (Check all that apply): Hospitalization for pulmonary exacerbation in the first year of life
 Chest radiography abnormalities (persist when stable)
 Weight for length less than 10th percentile Weight: _____ Height: _____ Date: _____
- Severe Immunodeficiency:** _____ ICD-10: _____ **Cardiac Transplantation** Date: _____
- Condition(s) affecting handling of respiratory secretions** and **less than 12 months** of age at the start of RSV season
 Patient has the following (Check all that apply): Congenital abnormality of the airway: _____ ICD-10: _____
 Neuromuscular condition: _____ ICD-10: _____

V. REQUESTED DRUG AND STRENGTH

Synagis® (palivizumab) 50mg 100mg Patient Weight: _____ Dose: _____ (15mg/kg)

Physician's Signature: _____ Date: ____/____/____