UnitedHealthcare
Community Plan

2017-2018 Synagis® Season
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.**

Fax: 866-940-7328 | Phone: 800-310-6826

Patient Information (Please complete the following or send patient demographic sheet.)		
Patient Name:	Insurance ID #:	
Parent/Guardian Name:	Home Phone:	
Address:	Alternate Phone:	
ICD-10 Code:	DOB (mm/dd/yyyy):	Sex: ☐M ☐ F

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

Clinical

Patient's gestational age (required): ________weeks ________days

Is patient from a multiple birth?: ☐ No ☐ Yes

Current weight in: ________kilograms ________pounds Date recorded: ___________________________

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

Require more than 21 percent oxygen at least 28 days after birth: ☐ No ☐ Yes

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 ☐ No ☐ Yes ICD-10 code:____(attach medical history)

Is there acyanotic heart disease?: ☐ No ☐ Yes

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

Does patient require cardiac surgical procedure?: ☐ No ☐ Yes

Was there consultation with pediatric cardiologist during first year of life?: ☐ No ☐ Yes

Please list cardiac medications:

____Last date received:__________________

____Last date received:__________________

____Last date received:__________________

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

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

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

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

Insurance ID #:_________________________Patient Name:_________________________Patient DOB:______/______/______

Clinical (continued)

Does patient have Cystic Fibrosis? ☐ No ☐ Yes (If Yes, attach medical history.) ICD-10 code: ___________

Was/has there been prior hospitalization for pulmonary exacerbation in first year of life? ☐ No ☐ Yes (If Yes, attach medical history.)

Was/has there been an abnormal chest radiography or chest computer tomography that persists when stable? ☐ No ☐ Yes (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 dose	
☐ Rx Epinephrine	1:1000 amp	Inject 0.01 mg/kg subcutaneously as directed for anaphylaxis	QS	

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

Which months are requested for the 2017-2018 season? (Circle) Nov. Dec. Jan. Feb. Mar. Other (specify) ______

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

Does patient have allergies?: ☐ No ☐ Yes If Yes, please list: ____

List other medical history: ____

Has the child been previously approved for Synagis by another insurance carrier for the 2017-2018 season? ☐ No ☐ Yes (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:	DEA #:	NPI #:
Address:	Phone:	
Suite:	Fax:	
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:________________________ID#:__________Subscriber:____________	Phone
Secondary: Name of insurer:______________________ID#:__________Subscriber:____________	Phone

IMPORTANT NOTICE: This electronic fax transmission, including any attachments contains information that may be confidential and/or privileged. The information contained in this facsimile is intended to be for the sole use of the individual(s) or entity named above. If you are not the intended recipient, be aware that any disclosure, copying, distribution or use of the contents of this information is strictly prohibited by law and will be vigorously prosecuted. If you have received this electronic fax transmission in error, please notify the sender immediately and destroy all electronic hard copies of the communications including attachments.