

## 2016–2017 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 800-897-8317. 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 UnitedHealthcare Community Plan Prior Authorization Department 877-651-6677.

Fax: 800-897-8317 | Phone: 877-651-6677

### 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: <input type="checkbox"/> M <input type="checkbox"/> F

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

HCPCS/J Code:	HCPCS/J Code Description:	
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 \_\_\_\_\_

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**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: _____

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Insurance ID #: \_\_\_\_\_ Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Clinical (continued)

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: \_\_\_\_\_

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, please 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
<input type="checkbox"/> Rx Synagis® (palivizumab)	50 and/or 100mg vials	Inject 15mg/kg IM one time per month	Other: QS to achieve 15mg/kg dose	
<input type="checkbox"/> 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 2016-2017 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 2016–2017 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 to BriovaRx.)

**Primary:** Name of insurer: \_\_\_\_\_ ID#: \_\_\_\_\_ Subscriber: \_\_\_\_\_ Phone: \_\_\_\_\_

**Secondary:** Name of insurer: \_\_\_\_\_ ID#: \_\_\_\_\_ Subscriber: \_\_\_\_\_ Phone: \_\_\_\_\_