UnitedHealthcare
Community Plan

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 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 UnitedHealthcare Community Plan Prior Authorization Department 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: _____

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
☐ 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 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: _____