Synagis respiratory syncytial virus (RSV) enrollment form

Today's date: ____________________ **Need by date:** __________________

Complete this form for UnitedHealthcare Community Plan members needing a Synagis® prescription and fax it to the pharmacy 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 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 pharmacy 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: ☐ M ☐ F
Medical information (Attach medical records, hospital discharge summary or other evidence that support each diagnosis.)	
ICD-10 code:	**Diagnosis description:**
Clinical	
Member gestational age (required): weeks days	**Is member from a multiple birth?** **Sex:** ☐ M ☐ F
Current weight in: kilograms pounds	**Date recorded:**
Chronic lung disease (CLD): ☐ Yes ☐ No ICD-10 code: (attach medical history) Requires more than 21% oxygen at least 28 days after birth? ☐ Yes ☐ No Therapy received within 6 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: (attach medical history)	
Is there acyanotic heart disease? ☐ Yes ☐ No	

Clinical (cont.)

Is there cyanotic heart disease? ☐ Yes ☐ No

Is there moderate to severe pulmonary hypertension? ☐ Yes ☐ No

Has the member received, or will they require a cardiac surgical procedure?

Yes ☐ No ☐ (If yes, attach medical history)

Was there a consultation with a pediatric cardiologist during the member's first year of life? ☐ Yes ☐ No

List of cardiac medications:	Last date received:
	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:
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 1 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? ☐ Nov. ☐ Dec. ☐ Jan. ☐ Feb. ☐ March

Other (specify)

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

Does member have allergies? ☐ Yes ☐ No (If yes, please list):

Prescription information (cont.)		
List other medical history:		
Has the child been previously approved for Synagis by another insurance carrier for the season? ☐ Yes ☐ No (If yes, 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 (DEA) 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 form.)	
Primary: Name of insurer:	Phone:
Subscriber name:	ID number:
Secondary: Name of insurer:	Phone:
Subscriber name:	ID number:

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.

PCA-1-23-01047-C&S-WEB_04112023
© 2023 United HealthCare Services, Inc. All Rights Reserved.