OPTUM®

Synagis Team
Phone: 888-293-9309 option 1
Fax: 866-391-1890

RSV / Synagis Enrollment / Prescription Form

Specialty Pharmacy Enrollment Form Please detach before submitting to a pharmacy – tear here.

PATIENT INFORMATION *(Section must be completed to process prescription)*

Patient Name _____ DOB _____ Gender: ☐ M ☐ F

Parent / Guardian _____ Last Four of SS# _____ Home Phone _____

Address _____ Alternate Phone _____

City _____ State & ZIP _____ Language Preference: ☐ English ☐ Spanish ☐ Other _____

INSURANCE INFORMATION *(Must fax a copy of patient's insurance card including both sides)*

Prior Authorization Reference number _____

PHYSICIAN INFORMATION AND PRESCRIPTION FOR SYNAGIS

Referring Physician _____ NPI # _____

Practice Name _____ DEA # _____

Address _____ Phone # _____

Medicaid Prescriber # _____ Office Contact _____ Fax # _____

NEXT injection OR FIRST injection due. Date _____ Has first dose been given? ☐ Yes ☐ No If Yes, When? _____ Where? _____

Subsequent injections will be administered in: ☐ Hospital ☐ MD Office ☐ Patient's Home ☐ Other _____

☐ Check here to have us coordinate nursing for in-home injections. *(service available in select regions)*

Preferred home health agency, if any _____ Already in the home? _____

PRESCRIPTION INFORMATION

Medication	Strength	Directions	Quantity	Total Doses Requested
☐ Rx Synagis®	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	

Previous injections (including doses given in hospital): ☐ Yes ☐ No If Yes, dates: _____

Which months are requested for the current season? (Circle) Nov. Dec. Jan. Feb. Mar. Other (specify) _____

Specialty pharmacy to coordinate injection training/home health nurse visit as necessary ☐ Yes ☐ No

Allergies: ☐ Yes ☐ No If Yes, please list: _____

Other medical history: _____

Has the child been previously approved for Synagis by another insurance carrier for the current season? ☐ Yes ☐ No
(Please attach approval from previous insurance carrier and clinical notes for doses already given)

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to: ☐ Patient ☐ Office ☐ Other _____ Date _____ Needs by Date _____

☐ Product Substitution permitted ☐ Dispense as Written

Prescriber's Signature _____ Date: _____ Supervising Physician Signature: _____ Date: _____
Electronic or digital signatures not accepted.

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone. This form is not a valid prescription in Arizona.

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CLINICAL INFORMATION

Patient's Gestational Age (Required):_____Weeks _____ Days

Patient is a multiple birth: ☐ No ☐ Yes

• Current weight in: _____ kilograms (kg) _____ pounds (lbs) Date recorded: _____

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

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

• Therapy received within 6 months start of RSV season (check all that apply):

☐ Supplemental oxygen: Last date _____

☐ Chronic systemic corticosteroid therapy: Last date _____ Drug name_____

☐ Diuretics therapy: Last date _____ Drug name _____

Congenital heart disease (CHD): ☐ No ☐ Yes ICD-10 Code: _____ (attach medical history)

• Acyanotic heart disease: ☐ No ☐ Yes

• Cyanotic heart disease: ☐ No ☐ Yes

• Moderate to severe pulmonary hypertension: ☐ No ☐ Yes

• Requires cardiac surgical procedure: ☐ No ☐ Yes

• In consultation with pediatric cardiologist during first year of life: ☐ No ☐ Yes

• List cardiac medications:

_____ Last date received: _____

_____ Last date received: _____

_____ Last date received: _____

Compromised handling of respiratory secretions: ☐ No ☐ Yes ICD-10 Code: _____ (attach medical history)

Congenital abnormality of the lower airway: ☐ No ☐ Yes ICD-10 Code: _____ (attach medical history)

Neuromuscular condition: ☐ No ☐ Yes ICD-10 Code: _____ (attach medical history)

Receiving chemotherapy: ☐ No ☐ Yes ICD-10 Code: _____ (attach medical history)

Cystic Fibrosis: ☐ No ☐ Yes ICD-10 Code: _____ (attach medical history)

• Prior hospitalization for pulmonary exacerbation in first year of life: ☐ No ☐ Yes (attach medical history)

• Abnormal chest radiography or chest computer tomography that persists when stable: ☐ No ☐ Yes

MEDICAL INFORMATION

ICD-10 Code: _____ Diagnosis: _____

ICD-10 Code: _____ Diagnosis: _____

List Meds and Dates _____ Ventilator and Dates _____