

Fax Request to (866) 546-2925. To speak with a representative call 866-522-2486. For Drug Delivery Questions call (866) 554-2673.

PATIENT DEMOGRAPHICS					
Patient Name: _____	Male <input type="checkbox"/> Female <input type="checkbox"/>	Insured Name: _____			
Address: _____	Apt #: _____	Insurance Co: _____			
City: _____	State: _____	Zip Code: _____	Insurance ID: _____		
Phone #: _____	Birth Date: _____	Group #: _____	SS#: _____		

PRIMARY DIAGNOSIS	
Gestational Age: Weeks _____ Days _____	Current Weight: _____ lbs _____ oz = _____ kg Date: _____
Chronological Age: Months _____ Weeks _____	Dose: 15 mg / kg x _____ kg = _____ mg
Birth Weight: _____ kg <input type="checkbox"/> lbs <input type="checkbox"/>	Months Synagis to be administered (Max 5 months): Nov <input type="checkbox"/> Dec <input type="checkbox"/> Jan <input type="checkbox"/> Feb <input type="checkbox"/> Mar <input type="checkbox"/>
<input type="checkbox"/> Congenital heart disease (747.0-747.9) <input type="checkbox"/> Chronic respiratory disease arising in the perinatal period (CLD) (770.7) <input type="checkbox"/> Other respiratory conditions of fetus/newborn (770.0-770.9) <input type="checkbox"/> Congenital anomalies of the respiratory system (748.0) <input type="checkbox"/> Other: _____ <input type="checkbox"/> Secondary Diagnosis: _____	Gestational Age <input type="checkbox"/> <= 24 weeks GA (765.21-765.22) <input type="checkbox"/> 31-32 wks GA (765.26) <input type="checkbox"/> 25-26 wks GA (765.23) <input type="checkbox"/> 33-34 wks GA (765.27) <input type="checkbox"/> 27-28 wks GA (765.24) <input type="checkbox"/> 35-36 wks GA (765.28) <input type="checkbox"/> 29-30 wks GA (765.25) <input type="checkbox"/> 37 or > wks GA (765.29)

MEDICAL CRITERIA (Please check appropriate boxes in ONE COLUMN ONLY and provide documentation as requested below)					
Gestational Age	<input type="checkbox"/> < 29 weeks	<input type="checkbox"/> 29 wks - < 32	<input type="checkbox"/> 32 wks - < 35 wks	<input type="checkbox"/> < 35 wks	<input type="checkbox"/> Any age
Chronological Age as of 11/1/09	<input type="checkbox"/> < 12 mo	<input type="checkbox"/> < 6 mo	<input type="checkbox"/> < 3 mo	<input type="checkbox"/> < 12 mo	<input type="checkbox"/> < 24 mo
	<input type="checkbox"/> 1st RSV season		Must have 1 or more listed condition: <input type="checkbox"/> Siblings <5yrs old <input type="checkbox"/> Attends day care	<input type="checkbox"/> Congenital airway abnormality Specify: _____ <input type="checkbox"/> Severe neuromuscular disease Specify: _____	<input type="checkbox"/> Hemodynamically significant congenital heart disease <input type="checkbox"/> Chronic lung disease (BPD - 770.70) treatment after 5/1/09 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Diuretic: _____ <input type="checkbox"/> Bronchodilator: _____ <input type="checkbox"/> Supplemental O2 Therapy <input type="checkbox"/> Other: _____
Required Documents	*5 DOSE MAX NICU Discharge Summary	*5 DOSE MAX NICU Discharge Summary	*3 DOSE MAX (up to chronological age of 90 days) NICU Discharge Summary	*5 DOSE MAX NICU Discharge Summary	*5 DOSE MAX Clinical notes from the pediatrician/specialist including diagnosis and treatments for the last 6 months

PATIENT CURRENT MEDICATION PROFILE (use additional sheet if needed)			
Medication	Strength	Dose	Any Known Allergies:
_____	_____	_____	_____
_____	_____	_____	_____

Deliver to: Physician Office Patient's Home

Rx	
Synagis 50mg or Synagis 100mg Dispense Quantity: QS Sig: Inject 15mg/kg IM once/month Refill Monthly: _____ months	
Physician Name (Print): _____	NPI #: _____ DEA #: _____
Ship to Address: _____	Suite/Apt: _____ Contact: _____
City: _____	State: _____ Zip: _____ Phone #: _____ Fax #: _____
Physician Signature: _____	Medically Necessary

Form Effective Date 10/01/09