

Physician Request Form for Synagis®

Fax to ICORE Healthcare at 800-327-4561. To speak to a representative call 866-554-2673.

Patient Demographics

Patient Name: _____ Male Female 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: _____ Weeks _____ Months	Dose: 15 mg / kg x _____ kg = _____ mg
Birth Weight _____ kg <input type="checkbox"/> lbs <input type="checkbox"/>	Months Synagis to be administered: 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 wks 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 the boxes and provide documentation as requested below)

Gestational Age	< 29 wks <input type="checkbox"/>	29 wks – < 32 <input type="checkbox"/>	32 wks – < 35 wks <input type="checkbox"/>	All Ages <input type="checkbox"/>
Chronological Age as of 11/1/08	< 12 mo <input type="checkbox"/>	< 6 mo <input type="checkbox"/>	< 6 mo <input type="checkbox"/>	< 24 mo <input type="checkbox"/>
Qualifying Criteria	<input type="checkbox"/> 1 st RSV season		Must have 2 or more listed conditions: <input type="checkbox"/> School age siblings List ages: _____ <input type="checkbox"/> Attends day care Days per wk: _____ Hrs per day: _____ Class size: _____ <input type="checkbox"/> Unavoidable environment air pollutants Specify: _____ <input type="checkbox"/> Congenital airway abnormality Specify: _____ <input type="checkbox"/> Severe neuromuscular disease Specify: _____	<input type="checkbox"/> Hemodynamically significant heart disease <input type="checkbox"/> Bronchopulmonary dysplasia (BPD) treatment after 05/01/2008 <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes provide medications) <input type="checkbox"/> Diuretic: _____ <input type="checkbox"/> Bronchodilator: _____ <input type="checkbox"/> Oxygen: <input type="checkbox"/> PRN <input type="checkbox"/> Daily <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____
Required Documents	NICU Discharge Summary	NICU Discharge Summary	NICU Discharge Summary	Clinical notes from the pediatrician/specialist including treatments for the last six months.

Patient Current Medication Profile

Medication	Strength	Dose	Any Known Allergies:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Synagis® Order 15 mg / kg

Synagis Receive Date: _____ Shipping Instructions (e.g. closed Wednesdays): _____
 Physician Name (Print): _____ License #: _____
 Ship To Address: _____ DEA #: _____
 Suite / Apt: _____ Contact: _____
 City: _____ Phone Number: _____
 State: _____ Zip Code: _____ Fax Number: _____
 Physician Signature: _____
 Medically Necessary