2012-2013 Synagis® Season Respiratory Syncytial Virus Enrollment Form

Fax form and NICU summary directly to UnitedHealthcare Community Plan Pharmacy Prior Notification Service at: 866-940-7328.

UnitedHealthcare Community Plan Prior Notification Service: 800-310-6826 (phone)

UnitedHealthcare Community Plan

Today's Date: Injection Date:

Patient information (Complete the following or send patient demographic sheet)

Patient Name:

Address:

City, St., Zip: County:

Home Phone: Alternate Ph.:

Date of Birth: Gender: Parent/Guardian Name:

Prescriber information

Prescriber's Name:

State License #: UPIN: DEA #: NPI #:

Group or Hospital:

Address:

City, State Zip:

Phone: Fax:

Contact Person: Phone:

Insurance information

Include front and back of insurance and prescription drug cards.

☐ Check here if you've applied for Medicaid and send supporting documents.

Primary Insurance Subscriber: ID#:

Name of Insurer: Phone:

Secondary Insurance Subscriber: ID#:

Name of Insurer: Phone:

Diagnosis (Required): **ATTACH NICU DISCHARGE SUMMARY**

- ☐ < 24 weeks of gestation (765.21)
- ☐ 24 weeks of gestation (765.22)
- ☐ 25-26 weeks of gestation (765.23)
- ☐ 27-28 weeks of gestation (765.24)
- ☐ 29-30 weeks of gestation (765.25)
- ☐ 31-32 weeks of gestation (765.26)
- ☐ 33-34 weeks of gestation (765.27)
- ☐ 35-36 weeks of gestation (765.28)
- ☐ 37 weeks+ of gestation (765.29)
- ☐ Congenital Heart Disease (Specify ICD-9 _____)
- ☐ Chronic Respiratory Disease arising in the perinatal period (CLD) (770.7)
- ☐ Congenital Abnormality of Respiratory System (748.4 or 748._____)
- ☐ Other ICD9 code: _____

Ship to: ☐ Patient ☐ Office ☐ Other:

Patient Evaluation: For requests for doses to be administered prior to Nov. 1 or after Mar. 31, provide supporting reports from state or local health departments or the CDC

- Patient's gestational age *(Required)*: _____ weeks _____ days
  - Current age: _____ months • Current weight: _____ g/kg/lbs • Date recorded: _____
- Prematurity:
  - ☐ Gestational age of ≤ 28 weeks, 6 days and less than 12 months of age at the start of the RSV season
  - ☐ Gestational age of 29 weeks, 0 days – 31 weeks, 6 days and less than 6 months of age at the start of RSV season
  - ☐ Gestational age of 32 weeks, 0 days – 34 weeks, 6 days with the following risk factors AND less than 3 months of age at the start of RSV season AND:
    - ☐ Sibling or permanent resident in the home < 5 years of age: _____
    - ☐ Child care attendance (defined as 2 or more unrelated children > 4 hours per week)
      Date started: _____ OR will start: _____ Day Care Provider: _____
- Chronic Lung Disease (CLD/BPD) and less than 24 months at start of RSV Season? ☐ Yes ☐ No ICD-9: _____
  - Treatment for CLD within 6 months of onset of RSV season with: ☐ Continuous Oxygen/Date: _____ ☐ Corticosteroids/Date: _____ ☐ Diuretics/Date: _____ ☐ Bronchodilator/Date: _____
- Diagnosis of hemodynamically significant congenital heart disease (CHD) and less than 24months of age? ☐ Yes ☐ No ICD-9: _____
  - Patient has the following conditions: ICD-9: _____
    - ☐ Current/On-going treatment of congestive heart failure
    - ☐ Moderate-to-severe pulmonary hypertension
    - ☐ Cyanotic congenital heart disease (CHD)
    - ☐ Medications for CHF/CHD (list): _____ Last date received: _____
- Compromised handling of respiratory secretions AND less than 12 months at the start of RSV season. ☐ Yes ☐ No
  AND ☐ Congenital abnormality of the airway ICD-9: _____ ☐ Neuromuscular condition ICD-9: _____
- Multiple births? ☐ Yes ☐ No Names of sibling RSV candidates (please submit separate enrollment form) _____
- NICU History: ☐ Yes ☐ No If yes, NICU name: _____
- Was a NICU dose administered? ☐ Yes ☐ No If yes, date(s): _____ (Please include NICU summary)
- Previous injections? ☐ Yes ☐ No If yes, dates: _____ Expected date of first/next injection: _____
- List Allergies: _____
- Other medical history: _____

Prescription Information/Injection Training/Home Health Coordination:

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

*Agency of choice:

Medication	*Strength*	*Directions*	*Quantity*	*Refills*
☐ Rx Synagis® (palivizumab)	50 and/or 100mg vials	Inject 15mg/kg IM one time per month Other:	QS to achieve 15mg/kg dose	
☐ Rx Epinephrine	1:1000 amp	Inject 0.01 mg/kg subcutaneously as directed for anaphylaxis	QS	

Ancillary supplies and kits provided as needed for administration

☐ Prescriber has counseled parent/guardian on Synagis therapy and the Specialty Pharmacy may contact parent/guardian.

Product Substitution Permitted (signature(s) required) **(Date)**

Dispense As Written **(Date)**

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