



SYNAGIS PA REQUEST FORM

MUST BE COMPLETED BY PHYSICIAN AND FAXED TO OPTUMRX AT 1-888-491-9742

1. PATIENT INFORMATION

Form fields for Patient Information: Last Name, First Name, M.I., Street Address, City, State, ZIP, Day Telephone #, Night Telephone #, Mobile Telephone #, Date of Birth, Age, Gender, Parent/Guardian Name.

INSURANCE/MEDICAID INFORMATION

Form fields for Insurance/Medicaid Information: Primary/Medical Insurance/Medicaid, Secondary/Pharmacy Insurance, Cardholder Name & ID #, Group/Policy #, Insurance Telephone #, Employer, Medicaid #.

ALTERNATE SHIPPING ADDRESS*

Form fields for Alternate Shipping Address: Last Name, First Name, M.I., Street Address, City, State, ZIP.

2. PHYSICIAN INFORMATION

Form fields for Physician Information: Prescriber's Last Name, Prescriber's First Name, Hospital/Clinic, Office Contact, Street Address, City, State, ZIP, Telephone #, Fax #, E-Mail Address, Prescriber's License #, DEA #, UPIN#, Medicaid License #, Primary Care Physician Name, Phone #.

*Not required and/or necessary for Medicaid Fee-For-Service

STATEMENT OF MEDICAL NECESSITY - COMPLETE FOR THE CURRENT RSV SEASON

MEDICAL CRITERIA:

Medical Criteria form including Gestational Age, Birth Weight, Current Weight, Date Recorded, Prematurity, Chronic Lung Disease (CLD), Hemodynamically Significant Congenital Heart Disease (CHD), Profoundly Immunocompromised, and Pulmonary Abnormality or Neuromuscular Disorder.

OTHER RELEVANT MEDICAL HISTORY:

Empty box for Other Relevant Medical History.

NICU HISTORY: Form fields for NICU Name, Was There a NICU Dose Administered?, Did the Neonatologist Recommend Synagis Prior to Discharge?, Expected Date of First/Next Injection.

PREVIOUS HEALTH PLAN/INSURANCE HISTORY: Form fields for Was Dose Administered in Previous Health Plan?, Name of Previous Health Plan, Phone #.

Rx: Form fields for Synagis (palivizumab) 50 and/or 100 mg Vials, Sig, Dispense Quantity, Refill, Product to be Administered In, Was Dose Previously Administered in Office?.

Prescriber's Signature (Must be signed by the physician. Stamped signature not allowed.) Date

Signature and Date line.

3. FAX COMPLETED FORM TOLL-FREE TO OPTUMRX AT 1-888-491-9742