



Synagis – palivizumab

Member Information

Relationship (Circle)

Name _____
Enrollment / Cardholder ID _____
Group / Plan _____
Birth Date _____
Address _____
City State Zip _____

Subscriber Spouse Dependent
Gender (Circle)
Male Female

Gestational Age: _____
Birth Weight: _____
Current Weight: _____

Practitioner Information

Name _____
Agent / Contact Name _____
Specialty _____
Office / Clinic Name _____
Address _____
City State Zip _____
Phone () - _____
Fax () - _____
Email _____@_____

**Primary Diagnosis Condition /
Diagnosis Related – Reason for Request**

- Patient's primary diagnosis: _____
 - Chronic Respiratory Disease Arising in the Perinatal Period [CLD] (770.7)
 - Congenital Abnormality of Respiratory System (748.3 – 748.4)
 - Congenital Heart Disease (747.0 – 745.4)
- Does the patient have bronchopulmonary dysplasia (BPD)? Y / N
- Diagnosis of hemodynamically significant congenital heart disease? Y / N
- Is the patient receiving medical treatment? (check all that apply) Y / N
 - Oxygen Bronchodilator Diuretic Corticosteroids
- Has the following risk factors? (check all that apply) Y / N
 - Congenital abnormality of the airway Day Care Attendance
 - Severe Neuromuscular Disease School Age Siblings
 - Exposure to Environmental Pollutants (not including tobacco smoke)

Strength / Dose / Frequency

Duration of Therapy (Expected)

**Formulary Alternatives
Attempted/Outcome**

Clinical Drug / Lab History Pertinent to Request

Contact Pharmacy? Y N

Practitioner Signature

Date Received: _____
Reviewed By: _____
Forwarded To: _____

**FAX Form to
877-800-5633**