



Synagis Prescription and Prior Authorization Request Form/2011-2012 RSV Season
Fax to 1-888-325-6544 (GHP c/o Walgreens)
Phone inquiries 1-888-347-3416

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|--------------------------------------|-----------------------------|
| Patient Name (Last, First) _____ | Gateway Member ID _____ |
| Phone _____ | |
| Parent/Guardian Name _____ | |
| Other Insurance (Name and ID#) _____ | |
| Physician Name _____ | Office Contact _____ |
| Office Phone _____ | Office Fax _____ |
| Office Address: | |
| Number and Street _____ | City, State, Zip Code _____ |

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| RX: Synagis (palivizumab) 50 mg and/or 100 mg vials Quantity: QS Refill _____ Required by date: _____ Prescriber's signature (substitution permissible) _____ | Directions: Administer 15 mg/kg IM once monthly Date _____ |
| <small>***In order for a brand name product to be dispensed, the physician must handwrite "Brand Medically Necessary" in the space provided</small> | |

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|---|--|
| Patient's Date of Birth (MM/DD/YYYY) | |
| Gestational age at Birth (Weeks and Days) | |
| Birth Weight | Weight: |
| Current Weight | Weight: Date: |
| Age as of 11/1/2011 | <input type="checkbox"/> < 3 months <input type="checkbox"/> 3-5 months <input type="checkbox"/> 6-11 months <input type="checkbox"/> 12-24 months |
| Hemodynamically significant congenital heart disease <input type="checkbox"/> No <input type="checkbox"/> Yes. Please specify to the right. | Please check all that apply <input type="checkbox"/> CHF <input type="checkbox"/> Cyanotic Heart Disease Medications used, please specify below: _____ _____ _____ |
| Chronic Lung Disease <input type="checkbox"/> No <input type="checkbox"/> Yes. Please specify _____ | Therapies used within the last 6 months. Please check all that apply <input type="checkbox"/> Supplemental O2 <input type="checkbox"/> Bronchodilator(s) <input type="checkbox"/> Diuretic(s) <input type="checkbox"/> Corticosteroid(s) |
| Risk Factors | Please check all that apply. <input type="checkbox"/> Severe neuromuscular disease <input type="checkbox"/> Daycare attendance <input type="checkbox"/> Congenital abnormalities of the airways <input type="checkbox"/> Sibling(s) < 5 years of age |
| NICU History | NICU dose given, Date: _____ |