Synagis Prescription and Prior Authorization Request Form/2012-2013 RSV Season
Fax to 1-888-325-6544 (GHP c/o Walgreens)
Phone inquiries 1-888-347-3416

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 __________________________________

RX: Synagis (palivizumab) 50 mg and/or 100 mg vials Directions: Administer 15 mg/kg IM once monthly
Quantity: QS Refill _____ Required by date: __________
Prescriber's signature ____
Date_______________

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	□ < 3 months □ 3-5 months □ 6-11 months □ 12-24 months
Hemodynamically significant congenital heart disease □ No □ Yes. Please specify to the right.	Please check all that apply □ CHF □ Cyanotic Heart Disease Medications used, please specify below: ____________________ ____________________ ____________________
Chronic Lung Disease □ No □ Yes. Please specify _________________________	Therapies used within the last 6 months. Please check all that apply □ Supplemental O2 □ Bronchodilator(s) □ Diuretic(s) □ Corticosteroid(s)
Risk Factors	Please check all that apply. □ Severe neuromuscular disease □ Daycare attendance □ Congenital abnormalities of the airways □ Sibling(s) < 5 years of age – specify if twins or multiple births and ages:____
NICU History	NICU dose given, Date: __________