BlueCross BlueShield of Delaware

Physician Request Form for Synagis®'

2011-2012 Season

Fax Request: 866-546-2925 Speak with a Representative: 866-522-2486 Drug Delivery Questions: 866-554-2673

PATIENT DEMOGRAPHICS

Patient Name: _____ Male ☐ Female ☐ Insured Name: _____

Address: _____ Apt #: _____ Insurance Co: _____

City: _____ State: _____ Zip Code: _____ Insurance ID: _____

Phone #: _____ Birth Date: _____ Group #: _____ SS#: _____

PRIMARY DIAGNOSIS

Gestational Age: Weeks _____ Days _____

Chronological Age: Months _____ Weeks _____

Birth Weight: _____ kg ☐ lbs ☐

Current Weight: _____ lbs _____ oz = _____ kg Date: _____

Dose: 15 mg / kg x _____ kg = _____ mg

Synagis Therapy Start Date: _____

*Maximum dispense is 5 monthly doses October through March

☐ Congenital heart disease (747.0-747.9)

☐ Chronic respiratory disease arising in the perinatal period (CLD) (770.7)

☐ Other respiratory conditions of fetus/newborn (770..0-770.9)

☐ Congenital anomalies of the respiratory system (748.0)

☐ Other: _____ ☐ Secondary Diagnosis: _____

Gestational Age

☐ < = 24 weeks GA (765.21-765.22) ☐ 31-32 wks GA (765.26)

☐ 25-26 wks GA (765.23) ☐ 33-34 wks GA (765.27)

☐ 27-28 wks GA (765.24) ☐ 35-36 wks GA (765.28)

☐ 29-30 wks GA (765.25) ☐ 37 or > wks GA (765.29)

MEDICAL CRITERIA (Please check appropriate boxes in ONE COLUMN ONLY and provide documentation as requested below)

Gestational Age	☐ < 29 weeks	☐ 29 wks - < 32	☐ 32 wks - < 35 wks	☐ < 35 wks	All ages ☐
Chronological Age as of 11/1/11	☐ < 12 mo	☐ < 6 mo	☐ < 3 mo	☐ < 12 mo	< 24 mo ☐
	*5 DOSE MAX	*5 DOSE MAX	Must have 1 or more listed conditions: ☐ Siblings <5yrs old ☐ Attends day care *3 DOSE MAX	☐ Congenital airway abnormality Specify:_____ ☐ Severe neuromuscular disease Specify:_____ *5 DOSE MAX	☐ Hemodynamically significant congenital heart disease ☐ Chronic lung disease treatment after 5/1/11 ☐ Yes ☐ No (if yes provide medications) ☐ Diuretic: _____ ☐ Bronchodilator: _____ ☐ Supplemental O2 Therapy ☐ Other: _____ *5 DOSE MAX
Required Documents	**NICU Discharge Summary**	**NICU Discharge Summary**	**NICU Discharge Summary**	**NICU Discharge Summary**	**Clinical notes from the pediatrician/specialist including treatments for the last 6 months**

PATIENT CURRENT MEDICATION PROFILE

Medication	**Strength**	**Dose**	**Any Known Allergies:**
_____	_____	_____	_____

Deliver to: ☐ Physician Office ☐ Patient's Home

Rx

Synagis 50mg or Synagis 100mg Dispense Quantity: QS Sig: Inject 15mg/kg IM once/month Refill Monthly:_____months

Physician Name (Print): _____ NPI #: _____ DEA #: _____

Ship to Address: _____ Suite/Apt: _____ Contact: _____

City: _____ State: _____ Zip: _____ Phone #: _____ Fax #: _____

Physician Signature: _____ Medically Necessary

Synagis® is a registered trademark of MedImmune, LLC.

Form Effective Date 9/2011

BCBSD has selected ICORE Healthcare, an independent company and subsidiary of Magellan Health Services, as a partner to assist with its prior authorization program. Please be assured that both BCBSD and ICORE Healthcare are committed to protecting the privacy of your patients' health care information.