



REQUEST FOR SYNAGIS FOR RESPIRATORY SYNCYTIAL VIRUS (RSV) – OHANA HEALTHPLANS
TELEPHONE 1-888-505-1198 FAX 1-888-877-8239

Date of Request: _____

1. PATIENT INFORMATION *To be completed by the Physician and Staff*

Last Name	First Name	M.I.
Street Address		
City	State	ZIP
Day Telephone # (+Area Code)	Mobile Telephone # (+Area Code)	
Date of Birth (MM/DD/YYYY)	Member ID Number	Sex (Check One) <input type="checkbox"/> M <input type="checkbox"/> F
Parent/Guardian Name		

2. PHYSICIAN INFORMATION *To be completed by the Physician and Staff*

Prescriber's Last Name	Prescriber's First Name
Office Contact	
Street Address	
City	State ZIP
Telephone # (+Area Code)	Fax # (+Area Code)
Provider ID Number	DEA #
Primary Care Physician Name	Phone #

PHC3499-0606

RX

Synagis® (palivizumab) 50 and/or 100 mg Vials NKDA

Sig: Inject 15 mg/kg IM Once Monthly

Dispense Quantity: QS Refill _____ Months

Other: _____

Expected Date of First/Next Injection _____

Deliver Product to: Office Home Please send Synagis to office location above: Yes No

Will Agency Nurse Visit Home for Injection? Yes No
Wellcare has criteria for Synagis Treatment in the member's home - Please contact Wellcare Injectable Department for this information. Wellcare does not cover Synagis given by a non-participating pharmacies/nursing agencies.

Prescriber's Signature	Date
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WellCare is committed to protecting the privacy of your health information. We will hold your health information in confidence and will only use and disclose it in accordance with applicable law.

STATEMENT OF MEDICAL NECESSITY

Patient's Gestational Age _____ Wks _____ Days _____ Birth Weight _____ g/kg/lbs
 Current Weight _____ g/kg/lbs Date Recorded _____

Please Document All Diagnoses and Document to the Highest Degree of ICD-9 Detail
MEDICAL CRITERIA:

1. Diagnosis of Chronic Pulmonary Disease (CLD/BPD) & less than 24 months of age at Start of RSV Season? Yes No ICD-9 _____

Is Patient Receiving Medical Treatment of:

(Check all that apply and provide last date received)

- Oxygen Date _____ Corticosteroids Date _____
- Bronchodilator Date _____ Diuretics Date _____

2. Diagnosis of Hemodynamically Significant Congenital Heart Disease and less than 24 months of age at Start of RSV Season? Yes No ICD-9 _____

Patient HAS the following conditions:

- Diagnosis of Moderate-Severe Pulmonary Hypertension
- Cyanotic Heart Disease Acyanotic Heart Disease
- Medications for CHF _____ Last Received: _____

3. Prematurity

- Gestational Age of ≤ 28 Weeks & ≤ 12 Months at the Start of RSV Season
- Gestational Age of 29 Weeks – 32 Weeks & ≤ 6 Months at the Start of RSV Season
- Gestational Age of 33 Weeks – 35 Weeks & ≤ 3 months at the Start of RSV Season

AND Has ONE of the following Risk Factors:

(Check All That Apply)

- Child Care/Day Care Attendance School-Aged Siblings
- Severe Neuromuscular Disease (Neurological Disorders)
- Congenital Abnormalities of the Airway

OTHER MEDICAL HISTORY:

Additional Information:

Received Previous Injections this Season? Yes No Date _____

Was Synagis Authorized by Prior Insurance Plan this Season? Yes No

Insurance Company Name: _____ ID # _____

3. FAX COMPLETED FORM TOLL-FREE TO 'Ohana Health Plan @ 1-888-877-8239

'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona, Inc.