

**SYNAGIS (PALIVIZUMAB)
Request Form**



315 SW Fifth Avenue, Suite 900
Portland, Oregon 97204
503-416-4100 or 800-224-4840
800-735-2900 (TTY/TDD)
www.careoregon.org

FAX completed form and supporting medical records to 503-416-4722

* For assistance with urgent requests Monday-Friday 8 a.m.-5 p.m., call CareOregon at 800-224-4840 or 503-416-4100.*

**** All fields must be completed and legible for review ****

Usual processing time for a Synagis request is 3 business days, but the state regulations allow for up to 14 days.
 URGENT REQUEST: By selecting the expedited review and signing this form below, I certify that applying the standard review time frame will seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name and Specialty:	
Member ID#:		NPI#:	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Prescriber Office Phone:	Prescriber Office Fax:
Date Of Birth:	Current Weight (kg):	Prescriber Contact Person:	

Drug: SYNAGIS CPT: 90378 RSV MAB 50 mg	Directions: Inject 15 mg/kg IM one time per month	# Doses Requested: _____
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Please complete the following and attach supporting medical records:

Gestational age at birth: _____ weeks, _____ days
Risk factors: Child care or day care attendance 1+ siblings younger than 5 years in residence
 Other: _____

Younger than 24 months with chronic lung disease and has required medical therapy in the past 6 months (e.g. home oxygen, bronchodilators, diuretics and/or chronic corticosteroid therapy).

Younger than 24 months with hemodynamically significant congenital heart disease. ICD-9 _____
 Moderate to severe pulmonary hypertension
 Cyanotic congenital heart disease
 Medication(s) to control congestive heart failure
List current medications: _____

Other Pertinent History:

Please note: For the Synagis Season, this medication is only provided as a medical benefit and will be provided by Caremark Specialty Pharmacy (phone 800-237-2767). CareOregon will forward the authorization information to Caremark once approved.

Physician's Signature _____ **Date:** _____

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