

**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 503-416-8109

* For assistance with urgent requests Monday-Friday 8 a.m.-5 p.m., call CareOregon at 800-224-4840 or 503-416-4100. For assistance after hours, call Express Scripts at 877-526-2313. *

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

<input type="checkbox"/> 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#:		DEA#:	
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		Directions: Inject 15 mg/kg IM one time per month	# Doses Requested: _____
Please complete the following and attach supporting medical records:			
<input type="checkbox"/> Gestational age at birth: _____ weeks, _____ days Risk factors: <input type="checkbox"/> Child care or day care attendance <input type="checkbox"/> 1+ siblings younger than 5 years in residence <input type="checkbox"/> Other: _____			
<input type="checkbox"/> 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).			
<input type="checkbox"/> Younger than 24 months with hemodynamically significant congenital heart disease. ICD-9 _____ <input type="checkbox"/> Moderate to severe pulmonary hypertension <input type="checkbox"/> Cyanotic congenital heart disease <input type="checkbox"/> Medication(s) to control congestive heart failure List current medications: _____			
Other Pertinent History: _____ _____ _____			
Physician's Signature _____		Date: _____	
Signature of Person Transmitting to CVS Caremark: _____		Date: _____	

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (via return FAX) immediately and arrange for the return or destruction of these documents.