



REQUEST FOR SYNAGIS FOR RESPIRATORY SYNCYTIAL VIRUS (RSV) – GEORGIA WELLCARE
TELEPHONE 1-866-269-5251 FAX 1-866-455-6558

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 – 31 Weeks, 6 days & ≤ 6 Months at the Start of RSV Season
 Gestational Age of 32 Weeks – 34 Weeks, 6 Days & ≤ 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 Siblings younger than 5 yrs of age
 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 WellCare Health Plans @ 1-866-455-6558