Optum

RSV/Synagis Enrollment/Prescription Form

Optum Specialty Phone: 888-293-9309 option 1 | Optum Specialty Fax: 866-391-1890

Specialty Pharmacy Enrollment Form

This form is not a valid prescription in Arizona or Virginia

Please detach before submitting to a pharmacy – tear here.

PATIENT INFORMATION

(Section must be completed to process prescription)

Patient Name _____

Parent/Guardian _____

Address _____

City, State, Zip _____

Home Phone _____ Alternate Phone _____

DOB _____ Last Four of SS# _____ Gender ☐ M ☐ F

Language Preference: ☐ English ☐ Spanish ☐ Other _____

INSURANCE INFORMATION

(Must fax a copy of patient's insurance card including both sides)

Primary Insurance _____ ID # _____

Subscriber _____ Phone _____

Secondary Insurance** (i.e. Medicaid) _____ ID # _____

Subscriber _____ Phone _____

** Optum Specialty Pharmacy will no longer be able to fulfill referrals with a non-contracted Medicaid secondary plan. Providers may contact the patient's plan for alternative options.

PHYSICIAN INFORMATION AND PRESCRIPTION FOR SYNAGIS

Referring Physician _____

Practice Name _____

NPI # _____

DEA # _____

Address _____

City, State, ZIP _____

Medicaid Prescriber # _____ Office Contact _____

Phone _____ Fax _____

NEXT injection OR FIRST injection due. Date_____ Has first dose been given? ☐ Yes ☐ No

If Yes, When? _____ Where? _____

Subsequent injections will be administered in: ☐ Hospital ☐ MD Office ☐ Patient's Home*

☐ Other _____

* Please Note: Optum Specialty Pharmacy will *no* longer be able to coordinate nursing services for Synagis.

PRESCRIPTION INFORMATION

Medication	Strength	Directions	Quantity	Total Doses Requested
☐ Rx Synagis®	50 and/or 100 mg vials	Inject 15 mg/kg IM one time per month	Other: QS to achieve 15 mg/kg dose	
☐ Rx Epinephrine	1:1000 amp	Inject 0.01 mg/kg subcutaneously as directed for anaphylaxis	QS	

Previous injections (including doses given in hospital): ☐ Yes ☐ No If Yes, dates: _____

Which months are requested for the current season? (Circle) Nov. Dec. Jan. Feb. Mar. Other (specify) _____

Allergies: ☐ Yes ☐ No If Yes, please list:

Other medical history: _____

Has the child been previously approved for Synagis by another insurance carrier for the current season? ☐ Yes ☐ No

(Please attach approval from previous insurance carrier and clinical notes for doses already given)

* Prescriber Authorization: "I authorize this pharmacy and its representatives to act as my authorized agent, including but not limited to, attestations of medical necessity, to secure coverage and initiate the insurance prior authorization process for our shared patient, and to sign any necessary forms, where permitted by law and benefit plan sponsor, on my behalf as my authorized agent, including any required prior authorization forms and the receipt and submission of patient lab values and other patient data that support the prior authorization. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network."

Ship to: ☐ Patient* ☐ Office ☐ Other _____ Date _____ Date Needed _____

*Please Note: Optum Specialty Pharmacy will *no* longer be able to coordinate nursing services for Synagis.

☐ Product Substitution permitted ☐ Dispense as Written

Dispense as Written

Prescriber's Signature _____ Date _____

Electronic or digital signatures not accepted.

Substitution permitted

Prescriber's Signature _____ Date _____

Electronic or digital signatures not accepted.

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.

CLINICAL INFORMATION

Patient's Gestational Age (Required):_____Weeks _____ Days

Patient is a multiple birth: ☐ Yes ☐ No

• Current weight in: _____ kilograms (kg) _____ pounds (lbs) Date recorded: _____

• Has the patient received a Beyfortus™ injection this season? ☐ Yes ☐ No

Chronic lung disease (CLD): ☐ Yes ☐ No ICD-10 Code: _____ (attach medical history)

• Require more than 21% oxygen at least 28 days after birth: ☐ Yes ☐ No

• Therapy received within 6 months start of RSV season (check all that apply):

☐ Supplemental oxygen: Last date _____

☐ Chronic systemic corticosteroid therapy: Last date _____ Drug name_____

☐ Diuretics therapy: Last date _____ Drug name _____

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CLINICAL INFORMATION

(Clinical Information continued)

Congenital heart disease (CHD): ☐ Yes ☐ No ICD-10 Code: _____ (attach medical history)

- Acyanotic heart disease: ☐ Yes ☐ No
- Cyanotic heart disease: ☐ Yes ☐ No
- Moderate to severe pulmonary hypertension: ☐ Yes ☐ No
- Requires cardiac surgical procedure: ☐ Yes ☐ No
- In consultation with pediatric cardiologist during first year of life: ☐ Yes ☐ No
- List cardiac medications:

_____ Last date received: _____

_____ Last date received: _____

_____ Last date received: _____

Compromised handling of respiratory secretions: ☐ Yes ☐ No ICD-10 Code: _____ (attach medical history)

Congenital abnormality of the lower airway: ☐ Yes ☐ No ICD-10 Code: _____ (attach medical history)

Neuromuscular condition: ☐ Yes ☐ No ICD-10 Code: _____ (attach medical history)

Receiving chemotherapy: ☐ Yes ☐ No ICD-10 Code: _____ (attach medical history)

Cystic Fibrosis: ☐ Yes ☐ No ICD-10 Code: _____ (attach medical history)

- Prior hospitalization for pulmonary exacerbation in first year of life: ☐ Yes ☐ No (attach medical history)
- Abnormal chest radiography or chest computer tomography that persists when stable: ☐ Yes ☐ No

MEDICAL INFORMATION

ICD-10 Code: _____ Diagnosis: _____

ICD-10 Code: _____ Diagnosis: _____

List Meds and Dates _____ Ventilator and Dates _____
