

**1**

**PATIENT INFORMATION**

Last Name	First Name	Middle Initial
Street Address		City
County	State	ZIP Code <input type="checkbox"/> M <input type="checkbox"/> F
Date of Birth	Social Security Number	Sex
Parent/Guardian		
Day Telephone (+Area Code)	Night Telephone (+Area Code)	

**INSURANCE INFORMATION**

Include copies of the patient's insurance cards and drug benefit cards (front and back) to expedite benefit clearance.

**Community Health Plan (CHP)**

Primary Insurance	Secondary Insurance
Cardholder Name & Social Security Number (If Not Patient)	Cardholder Name & Social Security Number (If Not Patient)
<input type="checkbox"/> Healthy Options (HO) / CHIP <input type="checkbox"/> Basic Health (BH) <input type="checkbox"/> Public Employee Benefit Board (PEBB)	
Policy Number <b>800.440.1561 (Customer Care)</b>	Policy Number
Insurance Telephone Number (+Area Code)	Insurance Telephone Number (+Area Code)

**2**

**PHYSICIAN INFORMATION**

Prescriber's Name	Hospital/Clinic	Office Contact
Address	City/State/ZIP	Telephone Number (+Area Code)
Prescriber's License Number	DEA Number	Fax Number (+Area Code)
Medicaid Provider Number	UPIN Number	
Supervising Physician's Name (If Required for Mid-Level Practitioner)	License Number	

**3**

FAX COMPLETED FORM TO CHP PA Department 206-613-8873  
CHP PA Request Form is not required if this form is used.



**4**

**CLINICAL INFORMATION** (Please submit supporting documentation for the items checked):

**PRIMARY DIAGNOSIS**

Patient's Gestational Age (GA) \_\_\_\_\_ Birth Weight \_\_\_\_\_ kg (lb)  
Current Weight \_\_\_\_\_ kg (lb) Date Recorded \_\_\_\_\_

<input type="checkbox"/> Congenital Heart Disease (745.0-747.9)	<input type="checkbox"/> 29-30 weeks' GA (765.25)
<input type="checkbox"/> Chronic Respiratory Disease Arising in the Perinatal Period (CLD) (770.7)	<input type="checkbox"/> 31-32 weeks' GA (765.26)
<input type="checkbox"/> ≤24 weeks' GA (765.21-765.22)	<input type="checkbox"/> 33-34 weeks' GA (765.27)
<input type="checkbox"/> 25-26 weeks' GA (765.23)	<input type="checkbox"/> 35-36 weeks' GA (765.28)
<input type="checkbox"/> 27-28 weeks' GA (765.24)	<input type="checkbox"/> 37 or more week's GA (765.29)
<input type="checkbox"/> Other Respiratory Conditions of Fetus and Newborn (770.0-770.9)	<input type="checkbox"/> Congenital Anomalies of Respiratory System (748)
<input type="checkbox"/> Other _____	Secondary diagnosis (if applicable) _____

**MEDICAL CRITERIA**

- Diagnosis of chronic pulmonary disease (CLD/BPD) and less than 12 months of age?  Yes  No  
Is patient receiving medical treatment of (check all that apply and provide last date received):  Oxygen Date: \_\_\_\_\_  
 Corticosteroids Date: \_\_\_\_\_  Bronchodilator Date: \_\_\_\_\_  Diuretics Date: \_\_\_\_\_
- Diagnosis of hemodynamically significant congenital heart disease and less than 24 months of age?  Yes  No  
Patient has the following condition:  Diagnosis of moderate-severe pulmonary hypertension  
 Medications for CHD/CHF: \_\_\_\_\_ Last date received: \_\_\_\_\_
- Severe immunodeficiency: \_\_\_\_\_
- Prematurity:  Gestational age of ≤28 weeks and <12 months of age at the start of RSV season  
 Gestational age of 29-32 weeks and <6 months of age at the start of RSV season  
 Gestational age of 32-35 weeks and <6 months at the start of RSV season AND
- Clinically has the following risk factors (Check all that apply):  
 ≥ 3 School-age siblings  Severe neuromuscular disease  
 Daycare  Congenital abnormality of airway  
 Other \_\_\_\_\_

**NICU HISTORY:**

- Did the patient spend time in the NICU?  Yes  No If yes, please attach the NICU Discharge Summary  
Was RSV prophylaxis recommended by the NICU/HOSPITAL physicians for this patient?  Yes  No  
Was there a NICU/HOSPITAL dose administered?  Yes Date(s): \_\_\_\_\_  No

**EXPECTED DATE OF FIRST/NEXT INJECTION:** \_\_\_\_\_ Injection already given?  Yes Date(s): \_\_\_\_\_  No

Deliver product to:  Office  Patient's Home  Clinic Clinic Location: \_\_\_\_\_

**Rx**

Synagis® (palivizumab) 50- and/or 100-mg vials and Sterile Water for injection 10 mL (for lyophilized formulation only)\*  
Sig: Reconstitute as directed and inject 15 mg/kg IM one time per month (for lyophilized formulation only) OR  
Sig: Inject 15 mg/kg IM one time per month (for liquid formulation only)  
Dispense Quantity: QS Refill \_\_\_\_\_ months  
 Epinephrine 1:1000 amp. Sig: Inject 0.01 mg/kg as directed  Known Allergies: \_\_\_\_\_  
 Other \_\_\_\_\_  
Sig: \_\_\_\_\_  
Prescriber's Signature \_\_\_\_\_

\*Synagis® liquid formulation will be automatically substituted upon manufacturers' market release.