



Date: _____

PATIENT INFORMATION

Form with fields for Patient Name (First/Last), M.I., Sex, Date of Birth, Address (Street/City/ST/ZIP), Day/Evening Phone, Caregiver/Emergency Contact Name, Relationship to Patient, and Phone.

INSURANCE INFORMATION

Form with field for BCBS I.D. NUMBER.

PHYSICIAN INFORMATION

Form with fields for Physician Name, Clinic Name, Office Contact, Address (Street/City/ST/ZIP), License, UPIN, NPI, Phone, and Secure Fax Number.

STATEMENT OF MEDICAL NECESSITY

Form containing 8 numbered questions regarding medical necessity for Synagis, including coverage for infants/children, diagnosis of immune deficiency, congenital heart disease, chronic lung disease, gestational age, and risk factors.

MEDICAL HISTORY

Form with fields for Allergies, Height (Ht), Weight (Wt), and Date.

PRESCRIPTION AND ORDERS:

All approved requests will be forwarded to Option Care or Triessent; if another provider is requested, CHECK THIS BOX

Form for prescription and orders, including Synagis (palivizumab) administration instructions, Pediatric Anaphylaxis protocol, and Physician's Signature/Date fields.

Please fax or mail this form to: Blue Cross and Blue Shield of Nebraska, Pharmacy Department - UM, 7261 Mercy Road • Omaha, NE 68180-0001

Toll Free Fax: 877-232-6726 Phone: 877-999-2374
Local Fax: 402-548-4683 Phone: 402-343-3558

CONFIDENTIALITY NOTE: The information contained in this facsimile message is privileged and confidential information intended only for the use of the individual or entity named above.