



of Tennessee
plans for better health. plans for a better life.™
1 Cameron Hill Circle
Chattanooga, TN 37402
bcbst.com

SYNAGIS® ENROLLMENT FORM 2009 - 2010

Commercial
BlueCare and TennCare Select (medical claims only)
East Region
West Region
Cover Tennessee

Fax: 1-866-558-0789
Fax: 1-800-292-5311
Fax: 1-800-919-9213
Fax: 1-423-535-5268

Member Information

Patient's Name:	Sex: <input type="checkbox"/> M or <input type="checkbox"/> F	Patient's ID Number:
Subscriber Name:	Patient's Date of Birth:	
Address:	Insurance Group Number:	
City/State/Zip:	Phone (day):	(night):

Statement of Medical Necessity

Primary Diagnosis:

- | | | |
|---------------------------------|---|--|
| <input type="checkbox"/> 765.0 | Extreme Immaturity (gestation of < 27 completed weeks) | Estimated Gestational Age: _____ |
| <input type="checkbox"/> 765.24 | Preterm infants (gestation of 27-28 completed weeks) | Estimated Gestational Age: _____ |
| <input type="checkbox"/> 765.25 | Preterm infants (gestation of 29-30 completed weeks) | Estimated Gestational Age: _____ |
| <input type="checkbox"/> 765.26 | Preterm infants (gestation of 31-32 completed weeks) | Estimated Gestational Age: _____ |
| <input type="checkbox"/> 765.27 | Preterm infants (gestation of 33-34 completed weeks) | Estimated Gestational Age: _____ |
| <input type="checkbox"/> 765.28 | Preterm infants (gestation of 35-36 completed weeks) | Estimated Gestational Age: _____ |
| <input type="checkbox"/> 770.7 | Chronic Respiratory Disease Arising in the Perinatal Period | |
| <input type="checkbox"/> 746.9 | Unspecified anomaly of heart | Actual Cardiac Diagnosis Code: _____ |
| <input type="checkbox"/> 748.9 | Unspecified anomaly of respiratory system | Actual Respiratory Diagnosis Code: _____ |
| <input type="checkbox"/> 358.9 | Myoneural disorders, unspecified | Actual Neuromuscular Diagnosis Code: _____ |

- Preterm infants from 32-35 weeks gestation (i.e., defined as 32 weeks, 0 days, through 34 weeks, 6 days) who were born less than 3 months before the onset (August 1 through October 31) or during the current RSV season (November 1 through March 31) with **ANY ONE** of the following risk factors:
- Infant attends child care (defined as a home or facility where care is provided for any number of infants or young toddlers)
 - Infant has a sibling younger than 5 years of age

Statement of Need and Pertinent Medical History (including previous treatments): _____

Current Weight: Date: _____ Weight: _____ kg Allergies: _____

Respiratory History: _____ Any respiratory therapy at home: ___ Yes ___ No

Cardiac History: _____ Recent/Last Hospitalization: _____ Date: _____

Date of first injection (if already given): _____ Anticipated date of next injection: _____

R_x PATIENT NAME _____ DATE _____
Synagis®, palivizumab, humanized RSV monoclonal antibody product with sterile water Quantity: _____ 50mg / 100 mg. Vials (number of vials)

Sig.: Inject 15 mg/kg one time per month Refill _____ months
Physician Signature _____ Use CPT® 90378 as the billing code
May Not Substitute

Physician Information

Physician Name:	Office Contact:
Hospital/Clinic:	Phone Number:
Address:	Fax Number:
City/State/Zip:	License Number: DEA Number:
National Provider Identifier:	Tennessee Medicaid Number:

INTERNAL USE ONLY:

BCBST Authorization: _____ (Signature) Reference/Authorization #: _____

Date of Service _____ to _____ 200__
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Confidential – This information is intended for the specific person or entity named above.

Revised 9/09