OPTUM®

SYNAGIS® REORDER FORM

To order now for next dose based on an estimated weight at time of injection, please fill out the information below and fax to **1-866-926-0463.**

PATIENT INFORMATION		
Patient's name:		
Insurance ID #:	Date of birth:	
Address:		Apartment #:
City:	State:	ZIP:
Phone Number:	Alternate Phone:	Sex: ☐ Male ☐ Female

PROVIDER AND SHIPPING INFORMATION			
Provider's name:	Physician ID (NPI/DEA):		
Address:	City:	State:	ZIP:
Suite number:	Building number:		
Phone number:	Fax number:		
Contact at the MD office:			
Office hours:	Alternative phone:	Extension:	

DELIVERY REQUEST
Next Synagis delivery date _____ (Tuesday to Friday only)
Pharmacist to dose next injection based on the following estimated weight: 1. Next injection date for Synagis _____ 2. Estimated patient's weight for next visit _____ kg Signature _____ Date _____

Please fax to **1-866-926-0463.** For more information call **1-888-293-9309.** Select **Option 1** for Synagis.

FOR INTERNAL USE ONLY.
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