

**SYNAGIS®**  
(palivizumab)

**SYNAGIS Prior Authorization  
Worksheet/Prescription Order Form.**

Please FAX or MAIL this completed form to  
CareSource: OH and MI Members  
P.O. Box 1307, Dayton, OH 45401  
Ph 1-800-488-0134 fax 1-888-752-0012



**PATIENT INFORMATION (BOLD ITEMS ARE REQUIRED)**

Patient's (Child's) Name: \_\_\_\_\_  M  F DOB: \_\_\_\_\_  
Gestational Age (GA) \_\_\_\_\_ Weeks \_\_\_\_\_ Days Birth Weight \_\_\_\_\_ lb/kg Current Weight \_\_\_\_\_ lb/kg Date: \_\_\_\_\_  
Patient's Address: \_\_\_\_\_ Daytime Phone: (\_\_\_\_) \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_ Evening Phone: (\_\_\_\_) \_\_\_\_\_  
Parent's Name: \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Best Time to Call: \_\_\_\_\_  
Member I.D. Number: \_\_\_\_\_ Other Insurance: \_\_\_\_\_

**Synagis criteria are based on 2009 American Academy of Pediatrics Red Book Guidelines. MEDICAL**  
**AUTHORIZATION CLINICAL CRITERIA (Please check ALL that apply.)**

Infant/Child's Condition	
<input type="checkbox"/>	≤ 28 6/7 weeks GA (≤ 12 months of age at start of RSV season) [5 dose max]
<input type="checkbox"/>	29 0/7 – 31 6/7 weeks GA (< 6 months of age at start of season) [5 dose max]
<input type="checkbox"/>	32 0/7 - 34 6/7 weeks GA (<3 months of age at start of RSV season); check all risk factors that apply [3 dose max up to age 90 days]
<input type="checkbox"/>	Other - Explain: _____
<b>Risk Factors Consideration</b>	
<input type="checkbox"/>	Siblings < 5 years of age
<input type="checkbox"/>	On O <sub>2</sub> /Airway Support
<input type="checkbox"/>	Child Care Attendance
Day Care Name/Ph#: _____	
<b>Diagnosis for Consideration (Please Check ALL that apply.)</b>	
<input type="checkbox"/>	Immunosuppressive/autoimmune disease
<input type="checkbox"/>	Severe Neuromuscular Disease
<input type="checkbox"/>	Congenital Abnormalities of Airways
<input type="checkbox"/>	Other _____
<b>Please note:</b> <b>Risk Factors for Consideration are subject to clinical and medical review</b>	
<input type="checkbox"/>	770.7 (Please document treatment and attach supporting documentation) →
<input type="checkbox"/>	_____ (745-747)
<b>Chronic Lung Disease/BPD: Infants and children ≤ 24 months</b> with Chronic Lung Disease (CLD) who have received treatment for the medical condition in the 6 months prior to RSV season. <b>Diagnosis:</b> _____ <b>Treatment:</b> Mechanical ventilation: yes / no Days/Duration _____ Supplemental oxygen: yes / no Days/Duration _____ Steroids and/or diuretics: yes / no Days/Duration _____ Other yes / no Days/Duration _____ <b>Cardiac (CHD) – Hemodynamically Significant:</b> Infants and children ≤ 24 months with hemodynamically significant cyanotic & acyanotic heart disease with moderate to severe pulmonary hypertension -747.83 or _____ with cyanotic congenital heart disease -746.9 or _____ who are receiving medication to control congestive heart failure -779.89_____ List medications: Other _____ Dx ICD-9 _____ Comments: _____	

**PRESCRIBER INFORMATION (REQUIRED)**

Prescriber's Name: \_\_\_\_\_ Medicaid TIN # \_\_\_\_\_ DEA# \_\_\_\_\_  
Practice Name: \_\_\_\_\_ NPI: \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Fax: \_\_\_\_\_ Synagis Contact: \_\_\_\_\_

**RX INFORMATION**

**SPECIAL INSTRUCTIONS:** \_\_\_\_\_

Synagis® (palivizumab) 50 mg and/or 100 mg vials **Sig:** Inject 15 mg/kg IM one time per month \_\_\_\_\_ # Doses  
**Date for first Injection:** \_\_\_\_\_ **Delivery to:**  Patient's Home  MD Office  
**Prescriber's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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