CareSource	SYNAGIS Prior Authorization **Please FAX this completed form to: 1-866-930-0019 Questions? Call 1-844-607-2831**	**SYNAGIS®** (palivizumab)

Patient Information (Bold Items Are Required)

Patient's (Child's) Name: _____ ☐M ☐F Date: _____

Gestational Age of Birth: Weeks__Days____ Birth Weight:_____lb/kg Current Weight:_____lb/kg DOB: _____

Patient's Address: _____

City/State/Zip: _____

Phone Number: (_____)_____Parent's Name: _____

Primary Insurance:_____ID # _____

Secondary Insurance:_____ID # _____

Synagis criteria arebased on 2014 American Academy of Pediatrics Guidelines. Medical Authorization Clinical Criteria (Please check ALL that apply.)

Infant/Child's Condition:

- ☐ < 29 0/7 weeks GA (≤ 12 months of age at start of RSV season)
- ☐ < 32 0/7 weeks GA with Chronic Lung Disease of Prematurity defined as a requirement > 21% oxygen for at least 28 days after birth.
- ☐ <32 0/7 weeks GA that are≤ 24 months with Chronic Lung Disease of Prematurity defined as a requirement > 21% oxygen for at least 28 days after birth and who continue to require medical intervention (supplemental oxygen, chronic corticosteroid or diuretic therapy)
- ☐ ≤ 12 months with hemodynamically significant congenital heart disease, those with cyanotic heart disease receiving medication for heart failure and will require cardiac medical procedures, and/or moderate to severe pulmonary hypertension
- ☐ ≤ 12 months with pulmonary abnormality or neuromuscular disease that impairs the ability to clear secretions from the respiratory tract
- ☐ ≤ 24 months that is considered profoundly immunocompromised*

Documented diagnosis must be confirmed by the individual's medical record and will need to be supplied with the prior authorization request. These medical records may include, but are not limited to test reports, chart notes from provider's office or hospital admission notes.

Chronic Lung Disease: Infants and Children ≤ 24 month and requires at least 28 days of supplemental oxygen after birth and who continue to require medical intervention

Diagnosis: _____

Mechanical ventilation: □ Yes □No Days / Duration _____

Supplemental oxygen: □ Yes □No Days/ Duration _____

Steroids and/or diuretics: □ Yes □No Days / Duration _____

Other:_____Days / Duration _____

Cardiac (CHD): Infants and Children ≤ 12 months with hemodynamically significant congenital heart disease : those with cyanotic heart disease, receiving medication for heart failure and will require cardiac medical procedures and/or moderate to severe pulmonary hypertension

- With moderate tosevere pulmonary hypertension
- With cyanotic congenital heart disease
- Receiving medication to control congestive heart failure List Medications: _____
- Diagnosis: _____

*** Other conditions:**

Diagnosis: _____

Comments:

Was there a hospital/NICU dose given? □ Yes □No Date Administered:_____

Drug Claim to be Submitted by:

☐ Prescribing Physician Dispensing Pharmacy(if other than CVS) _____

☐ CVS Caremark NPI#_____Address_____

☐ Other Phone_____Fax_____

Drug Claim to be submitted to:

☐ Medical Benefit

☐ Pharmacy Benefit

Place of Service:

☐ Physician's Office ☐ Member's Home, Administered by_____ ☐ Synagis Clinic

Prescribing Physician:

Physician Name_____ Prescriber Specialty _____

Phone_____ Fax_____

Office Contact_____ Address _____

Facility_____

City/State/Zip_____

License #_____DEA #_____NPI #_____

Approved Prior Authorizations are contingent upon the eligibility of member at the time of service and the claim timely fill limits. Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent upon eligibility and benefits.