

**SYNAGIS Prior Authorization**Please FAX this completed form to:
866-930-0019 for Pharmacy Benefit
or 888-399-0271 for Medical Benefit**SYNAGIS®**
(palivizumab)**Patient Information**

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 are based on 2014 American Academy of Pediatrics Guidelines. Medical Authorization Clinical Criteria (Please check ALL that apply.)Is this a multiple birth (twins, triplets, etc.)? Yes No**Pre-term birth:**

- < 12 months of age at the beginning of the RSV season
 Born < 29 weeks, 0 days gestation

Chronic Lung Disease of Prematurity:

Diagnosis/ICD-10: _____

- < 12 months of age at the beginning of RSV season with chronic lung disease of prematurity - defined as birth before 32 weeks, 0 days AND a requirement for > 21% oxygen for at least 28 days after birth
- 12-24 months of age at the beginning of the RSV season with chronic lung disease of prematurity - defined as birth before 32 weeks, 0 days gestation AND > 21% oxygen for at least 28 days OR after birth, member is treated with either corticosteroid or diuretic therapy within the 6-month period before the start of RSV season
- If patient is receiving medical treatment, check all that apply below and provide dates:
 - Oxygen _____ (dates _____)
 - Corticosteroid _____ (dates _____)
Please list drug(s): _____
 - Diuretic _____ (dates _____)
Please list drug(s): _____

Pulmonary/Neuromuscular Abnormalities:

Diagnosis/ICD-10: _____

- < 12 months of age at the beginning of RSV season with qualifying disease that impairs the ability to swallow/cough/clear secretions from the upper airways

Cystic Fibrosis:

Diagnosis/ICD-10: _____

- < 12 months of age at the beginning of the RSV season with clinical evidence of CLD and/or nutritional compromise in the first year of life
- 12-24 months of age at the beginning of the RSV season with one of the following:
- i) Manifestations of severe lung disease (previous hospitalization for pulmonary exacerbation in the first year of life, or abnormalities on chest radiography or chest computer tomography that persist when stable)
 - ii) Weight for length less than the 10th percentile on a pediatric growth chart

Congenital Heart Disease:

Diagnosis/ICD-10: _____

- < 12 months of age at the beginning of the RSV season with hemodynamically significant congenital heart disease with one or more of the following:
- i) Acyanotic heart disease [e.g., atrial septal defect (ASD), ventricular septal defect (VSD), etc.], AND member is receiving medication to control congestive heart failure (CHF) AND will require cardiac surgical procedures
 - ii) Moderate to severe pulmonary hypertension
 - iii) Cyanotic heart disease and referred by a pediatric cardiologist [e.g., coarctation of aorta, Ebstein's anomaly, hypoplastic left heart syndrome, Tetralogy of Fallot (TOF), Total Anomalous Pulmonary Venous Connection (TAPVC), etc.]

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.

Immunocompromised:

Diagnosis/ICD-10: _____

 0-24 months of age and considered profoundly immunocompromised:

- i) Stem cell transplant
- ii) Concurrent chemotherapy
- iii) Organ transplants (cardiac, liver, etc.)
- iv) Other conditional immunocompromised conditions

Other Conditions:

Diagnosis/ICD-10: _____

- Stem cell transplant
- Concurrent chemotherapy
- Organ transplant

Comments: _____

Was there a hospital/NICU dose given? Yes No Date Administered: _____**Drug Claim to be Submitted by:**

Prescribing Physician Dispensing Pharmacy _____
 Preferred Specialty Pharmacy NPI# _____ Address _____
 Other Phone _____ Fax _____

Drug Claim to be submitted to: Medical Benefit**Place of Service:**
 Physician's Office Member's Home, Administered by _____ Synagis Clinic
Prescribing Physician:

Physician Name _____ Prescriber Specialty _____
Office Contact _____ Phone _____ Fax _____
Facility _____ Address _____
City/State/Zip _____ Tax ID (required) _____
License # _____ DEA # _____ NPI # (required) _____

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.