CareSource RxInnovations	**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 Respiratory Syncytial Virus (RSV) season
☐ Born < 29 weeks, 0 days gestation

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 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.]

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
☐ Preferred Specialty Pharmacy
☐ Other

Dispensing Pharmacy _____
NPI#_____ Address _____
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 _____
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.