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

< 12 months of age at the start of RSV season:

- ☐ < 29 0/7 weeks GA
- ☐ < 32 0/7 weeks GA with Chronic Lung Disease of Prematurity defined as a requirement of supplemental oxygen for at least 28 days after birth
- ☐ Has hemodynamically significant Congenital Heart Disease (as defined below)
- ☐ Has pulmonary abnormalities or neuromuscular disorder that impairs ability to clear secretions from upper airways
- ☐ Is considered profoundly immunocompromised*
- ☐ Undergoes cardiac transplantation during RSV season
- ☐ Has Cystic Fibrosis and Chronic Lung Disease and/or nutritional compromise

12 to 24 months of age at the start of RSV season:

- ☐ < 32 0/7 weeks of GA with Chronic Lung Disease of Prematurity that required at least 28 days of oxygen after birth and who continues to require supplemental oxygen, chronic corticosteroid, or diuretic during 6 months before the start of RSV season
- ☐ Is considered profoundly immunocompromised*
- ☐ Undergoes cardiac transplantation during RSV season
- ☐ Has Cystic Fibrosis with either severe lung disease or weight for length less than 10th percentile on pediatric growth chart

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 (CLD): Diagnosis/ICD-10: _____

If patient is receiving medical treatment, check all that apply below and provide dates:

- ☐ Oxygen (dates _____)
- ☐ Corticosteroid _____ (dates _____)
- ☐ Diuretic _____ (dates _____)

Congenital Heart Disease (CHD): Diagnosis/ICD-10: _____

- ☐ With moderate to severe pulmonary hypertension
- ☐ With cyanotic heart defect and referred by a pediatric cardiologist
- ☐ With acyanotic heart disease and is receiving medication to control congestive heart failure and will require cardiac surgery
  List Medications: _____

*** Other conditions:**

Diagnosis/ICD-10: _____

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

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.