

**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
- 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, diuretic, or bronchodilator therapy during 6 months before the start of RSV season
- Is considered profoundly immunocompromised\*
- Undergoes cardiac transplantation
- Has Cystic Fibrosis with either severe lung disease or weight for length less than 10<sup>th</sup> 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 \_\_\_\_\_)
- Bronchodilator \_\_\_\_\_ (dates \_\_\_\_\_)

**Congenital Heart Disease (CHD):** Diagnosis/ICD-10: \_\_\_\_\_

- With moderate to severe pulmonary hypertension
- With cyanotic congenital heart disease
- With acyanotic heart disease and is receiving medication to control congestive heart failure and will require cardiac surgery  
List Medications: \_\_\_\_\_
- Previous cardiac or cardiopulmonary surgical procedures (e.g. cardiac bypass)

**\* 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 Dispensing Pharmacy \_\_\_\_\_
- Preferred Specialty Pharmacy 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 \_\_\_\_\_  
 Office Contact \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 Facility \_\_\_\_\_ Address \_\_\_\_\_  
 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.

GA-P-0438a

DCH Approved: 11/07/2019