SYNAGIS® (palivizumab)	**SYNAGIS Prior Authorization Worksheet/Prescription Order Form.** Please FAX or MAIL this completed form to CareSource: OH and MI Members P.O. Box 1307, Dayton, OH 45401 Ph 1-800-488-0134 fax 1-888-752-0012	CareSource

PATIENT INFORMATION (BOLD ITEMS ARE REQUIRED)

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

Gestational Age (GA) ____Weeks _____Days Birth Weight _____ lb/kg Current Weight _____lb/kg Date: _____

Patient's Address: _____ Daytime Phone: **(___)** _____

City/State/Zip: _____ Evening Phone: **(___)** _____

Parent's Name:_____ Cell Phone: **(___)** _____ Best Time to Call:_____

Member I.D. Number: _____ Other Insurance:_____

Synagis criteria are based on 2009 American Academy of Pediatrics Red Book Guidelines. **MEDICAL AUTHORIZATION CLINICAL CRITERIA** (Please check ALL that apply.)

	Infant/Child's Condition
☐	≤ 28 6/7 weeks GA (≤ 12 months of age at start of RSV season) [5 dose max]
☐	29 0/7 – 31 6/7 weeks GA (≤ 6 months of age at start of season) [5 dose max]
☐	32 0/7 - 34 6/7 weeks GA (<3 months of age at start of RSV season); check all risk factors that apply [3 dose max up to age 90 days]
☐	Other - Explain:

Risk Factors Consideration

☐ Siblings < 5 years of age
☐ On O_2/Airway Support
☐ Child Care Attendance
Day Care Name/Ph#: _____

Diagnosis for Consideration (Please Check ALL that apply.)

☐ Immunosuppressive/autoimmune disease
☐ Severe Neuromuscular Disease
☐ Congenital Abnormalities of Airways
☐ Other _____

Please note:
Risk Factors for Consideration are subject to clinical and medical review

☐ 770.7 (Please document treatment and attach supporting documentation) →

Chronic Lung Disease/BPD: Infants and children ≤ 24 months with Chronic Lung Disease (CLD) who have received treatment for the medical condition in the 6 months prior to RSV season.

Diagnosis: _____

Treatment:

Mechanical ventilation: yes / no Days/Duration _____
Supplemental oxygen: yes / no Days/Duration _____
Steroids and/or diuretics: yes / no Days/Duration _____
Other yes / no Days/Duration _____

☐ _____ (745–747)

Cardiac (CHD) – Hemodynamically Significant: Infants and children ≤ 24 months with hemodynamically significant cyanotic & acyanotic heart disease
with moderate to severe pulmonary hypertension -747.83 or _____
with cyanotic congenital heart disease -746.9 or _____
who are receiving medication to control congestive heart failure -779.89_____ List medications:
Other_____Dx ICD-9_____
Comments: _____

PRESCRIBER INFORMATION (REQUIRED)

Prescriber's Name: _____ Medicaid TIN #_____ DEA#_____

Practice Name:_____ NPI: _____

Address_____City_____ State_____ Zip_____

Phone_____ Fax: _____ Synagis Contact: _____

RX INFORMATION SPECIAL INSTRUCTIONS:_____

☐ **Synagis®** (palivizumab) 50 mg and/or 100 mg vials **Sig:** Inject 15 mg/kg IM one time per month _____ **# Doses**

Date for first Injection: _____ **Delivery to:** ☐ **Patient's Home** ☐ **MD Office**

Prescriber's Signature:_____ **Date:**_____