

SYNAGIS®
(palivizumab)

**SYNAGIS Prior Authorization
Worksheet/Prescription Order Form.**
Please FAX this completed form to
the member's managed care plan



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	
<input type="checkbox"/>	≤ 28 6/7 weeks GA (≤ 12 months of age at start of RSV season) [5 dose max]
<input type="checkbox"/>	29 0/7 – 31 6/7 weeks GA (≤ 6 months of age at start of season) [5 dose max]
<input type="checkbox"/>	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]
<input type="checkbox"/>	Other - Explain: _____
Risk Factors Consideration	
<input type="checkbox"/>	Siblings < 5 years of age
<input type="checkbox"/>	On O ₂ /Airway Support
<input type="checkbox"/>	Child Care Attendance
Day Care Name/Ph#: _____	
Diagnosis for Consideration (Please Check ALL that apply.)	
<input type="checkbox"/>	Immunosuppressive/autoimmune disease
<input type="checkbox"/>	Severe Neuromuscular Disease
<input type="checkbox"/>	Congenital Abnormalities of Airways
<input type="checkbox"/>	Other _____
Please note: Risk Factors for Consideration are subject to clinical and medical review	
<input type="checkbox"/>	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 _____	
<input type="checkbox"/>	_____ (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:** _____