AmeriHealth

Prior Authorization Form

Synagis ® (palivizumab)

Date: _____

Patient Name: _____ Patient DOB: _____

Patient Health Insurance ID #: _____ Office Contact: _____

Cardholder Name: _____ Day Phone: _____

Address: _____ Evening Phone: _____

City: _____ State: _____ Zip: _____

Prescribing Physician: _____ Office Phone #: _____

Provider NPI : _____ Office Fax #: _____

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1. PRIMARY DIAGNOSIS:

Patient's Gestational Age: _____ Birth Weight: _____

Current Weight: _____ Date Recorded: _____

☐ Chronic Respiratory Disease Arising in the Perinatal Period [CLD] (770.7) ☐ Congenital Heart Disease (747.0 – 745.4)

☐ Congenital Abnormality of Respiratory System (748.3 – 748.4) ☐ Other

2. PATIENT HISTORY:

a. Does patient have bronchopulmonary dysplasia [BPD]? ☐Yes ☐No

b. Diagnosis of hemodynamically significant congenital heart disease? ☐Yes ☐No

c. Is patient receiving medical treatment? (check all that apply) ☐Yes ☐No

☐ Oxygen, Date: _____ ☐ Corticosteroids, Date: _____

☐ Bronchodilator, Date: _____ ☐ Diuretics, Date: _____

d. Has the following risk factors:

☐ Day Care ☐ School Age Siblings ☐ Severe Neuromuscular Disease

☐ Exposure to Environmental Pollutants (☐ Includes Smoking ☐ Excludes Smoking)

Describe Pollutant:_____

☐ Congenital anomaly of the airway

Other Medical History

_____

_____

_____

e. Previous Injections? ☐Yes ☐No Expected date of 1st or next injection: _____

f. Does the patient have any allergies? ☐No ☐Yes: _____

Rx

☐ **Synagis® (palivizumab)** 50 and/or 100mg vials and Sterile Water for injection 10mL

Sig: Reconstitute as directed and inject 15 mg/kg IM one time per month Dispense Quantity: QS

Refill _____ months ☐Dispense as written ☐Substitution Allow

Prescriber Signature: _____ Date: _____

FAX TO (215) 761-9165. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.

INTERNAL USE ONLY

Document #: _____ LOB: _____ M F Previous Auth Y N

APPROVED Reviewer Initials: _____ Date: _____