

Today's date _____

Date medication needed _____

Prior Authorization Form Synagis® (palivizumab)



ONLY COMPLETED REQUESTS WILL BE REVIEWED

Patient information (please print)

Patient name _____ Subscriber name _____

Address _____ City, state, ZIP _____

Telephone # _____ Member ID # _____ Date of birth _____

Gestational age _____ Chronological age _____ Current weight _____ Date recorded _____

Does the patient have any allergies? Yes No

Previous injections? (including doses given in NICU) Yes: # of doses _____ Dates given _____

No: Expected date of 1st or next injection _____

Physician information (please print)

Prescribing physician _____ Prescriber NPI _____

Office address _____ City, state, ZIP _____

Office contact _____ Telephone # _____ Fax # _____

Diagnosis and patient history (check all that apply)

Chronic pulmonary disease (CLD/BPD) (specify ICD-9 code and complete a – h below) _____

Attach supporting documentation, including pulmonary consults.

- | | | |
|-------------------------------------------------------------------------------------------|--------------------------------------------------------|-----------------------------|
| a. Does patient have bronchopulmonary dysplasia (BPD)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Does patient have interstitial pulmonary fibrosis of prematurity? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Does patient have Wilson-Mikity syndrome? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Does patient have chronic obstructive asthma? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Does patient have chronic bronchitis? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Does patient have bronchiolitis? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. Other _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| h. Is patient receiving medical treatment? (check all that apply below and provide dates) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Oxygen (dates _____) | <input type="checkbox"/> Corticosteroids (dates _____) | |
| <input type="checkbox"/> Diuretics (dates _____) | <input type="checkbox"/> Bronchodilator (dates _____) | |

Congenital heart disease (CHD) — 747.0 to 745.4 (specify ICD-9 code; complete a – c below) _____

Attach supporting documentation, including latest cardiology consults, echocardiograms/catheterization records.

- | | | |
|-----------------------------------------------------------------------|------------------------------|-----------------------------|
| a. Diagnosis of hemodynamically significant congenital heart disease? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Diagnosis of moderate-severe pulmonary hypertension? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. List medications currently used to control CHD _____ | | |

Congenital abnormality of respiratory system — 748.3 to 748.4 (specify ICD-9 code) _____

Severe neuromuscular disease that compromises mobilization of resp. secretions (specify ICD-9 code) _____

Other diagnosis (specify ICD-9 code) _____

Prescription information

Synagis® (palivizumab): 50mg and/or 100mg vials and 10mL sterile water for injection

Sig: Reconstitute as directed and give 15 mg/kg intramuscular injection once per month

Dispense quantity _____ Refill x _____ month(s) Choose one: Dispense as written Substitution allowed

Physician's signature _____

Complete the following section only if gestational age is 32 to < 35 weeks and patient is under 3 months old.

Day care. Attends day care: No Yes: Name of day care _____ # of days/week _____

Siblings. Please list number of siblings and their age(s) _____

Fax completed form to 215-761-9165. Your office will receive a response by fax within two business days.