Prior Authorization Form Synagis® (palivizumab)

Today's date _____ **Date medication needed** _____

AmeriHealth

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 Synagis® (palivizumab) injections? (including doses given in NICU)

☐ Yes: # of doses _____ Dates given _____ Expected date of next injection _____

☐ No: Expected date of 1st 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)

☐ **Breakthrough RSV hospitalization during the current RSV season**

☐ **Chronic lung disease of prematurity (specify ICD-9 code; then complete a – b below)** _____

Attach supporting documentation, including pulmonary consults.

a. Does patient have chronic lung disease of prematurity? ☐ Yes ☐ No

b. Is patient receiving medical treatment? (check all that apply below and provide dates) ☐ Yes ☐ No

☐ Oxygen (dates _____) ☐ Corticosteroids (dates _____)

☐ Diuretics (dates _____) ☐ Bronchodilator (dates _____)

☐ **Congenital heart disease (CHD) (specify ICD-9 code; then complete a – d below)** _____

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

a. Diagnosis of hemodynamically significant acyanotic CHD? ☐ Yes ☐ No

b. Diagnosis of hemodynamically significant cyanotic CHD? ☐ Yes ☐ No

o Consultation with pediatric cardiologist regarding use of Synagis® (palivizumab)? ☐ Yes ☐ No

c. Diagnosis of moderate-to-severe pulmonary hypertension? ☐ Yes ☐ No

d. List of medications currently used to control congestive heart failure _____

☐ **Prematurity (gestational age 28 weeks, 6 days or younger)**

☐ **Severe neuromuscular disease or congenital abnormalities of the airway that compromise mobilization of respiratory secretions (specify ICD-9 code)** _____

☐ **Other diagnosis (specify ICD-9 code)** _____

Prescription information

☐ Synagis® (palivizumab): 50 mg and/or 100 mg 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)

Physician's signature _____

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