

SYNAGIS® PRIOR AUTHORIZATION REQUEST FORM FOR RESPIRATORY SYNCYTIAL VIRUS (RSV)

Instructions: Please complete ALL FIELDS and FAX COMPLETED FORM TO 1-866-354-8709.

Member Name:		Prescriber FULL Name/Specialty:
Member ID #:	Date of Birth:	Prescriber NPI:
Member's Telephone Number:		Office Address:
Diagnosis for use of the requested medication(s):		
Patient's Birth Weight:	Patient Current Weight (kg):	Contact Name at MD Office:
Patient's Gestational Age: Weeks _____ Days _____		Office Phone #:
Was the member part of a multiple birth? <input type="checkbox"/> Yes <input type="checkbox"/> No		Office Fax #:
DRUG REQUESTED (include strength and dosage form):		
Quantity:	Expected date of first/next injection:	
Received previous injections this season? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, date: _____		
REQUIRED DOCUMENTATION – Please submit all required clinical notes/lab reports in reference to this request.		
<p>1. Diagnosis of chronic pulmonary disease (CLD/BPD) and less than 24 months of age at start of RSV season? <input type="checkbox"/> Yes <input type="checkbox"/> No ICD-9 (REQUIRED) _____ Is patient receiving medical treatment of (only required for second year of life)? (Check all that apply and provide last date received): † Oxygen Date _____ †Corticosteroids Date _____ † Diuretics Date _____ Did the patient receive oxygen for at least the first 28 days after birth? <input type="checkbox"/> Yes <input type="checkbox"/> No _____% Oxygen (REQUIRED)</p> <p>2. Diagnosis of hemodynamically significant congenital heart disease and less than 2 years of age at start of RSV season? <input type="checkbox"/> Yes <input type="checkbox"/> No ICD-9 (REQUIRED) _____ Patient HAS the following conditions: † <input type="checkbox"/> Diagnosis of moderate-severe <input type="checkbox"/> Pulmonary hypertension † <input type="checkbox"/> Cyanotic heart disease <input type="checkbox"/> Acyanotic heart disease † Medications for CHF _____ Last Received: _____</p> <p>3. Prematurity † <input type="checkbox"/> Gestational age of < 29 Weeks & ≤ 12 months at the start of RSV season <input type="checkbox"/> Other _____</p>		
Other Medical History:		

By signing below, you attest that all statements on this form as true to the best of your knowledge.

Prescriber's Signature _____ Date _____