

**PRIOR AUTHORIZATION FORM - SYNAGIS® (PALIVIZUMAB)
COMPLETE AND FAX TO: 1-888-852-1832**

PATIENT INFORMATION			
First Name:		Last Name:	
ID Number:		Plan:	
Street Address:		City:	State: Zip:
Date of Birth:		Allergies:	
Patient's Phone Number:		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Patient's Gestational Age: weeks days		Birth Weight; kg/lbs	
Current Weight:		Date recorded:	
MEDICAL NECESSITY CRITERIA			
<input type="checkbox"/> 765.21 – 765.27 Gestational Age (please select below)			
<input type="checkbox"/> Prematurity ≤28 weeks		AND <12 months at the start of the RSV season	
<input type="checkbox"/> Prematurity 29 to 31 weeks 6 days		AND <6 months at the start of the RSV season	
<input type="checkbox"/> Prematurity 32 to 34 weeks 6 days		AND <3 months at the start of the RSV season	
Plus one of the following risk factors: <input type="checkbox"/> Daycare attendance <input type="checkbox"/> lives at home with siblings(s) who is (are) < 5 yrs old			
<input type="checkbox"/> Patient ≤ 12 months of age and diagnosis of chronic pulmonary disease (CLD/BPD) 770.7 Chronic Lung Disease			
<input type="checkbox"/> Patient ≤ 24 months of age and diagnosis of chronic pulmonary disease (CLD/BPD) 770.7 Chronic Lung Disease Plus one of the following txs (check all that apply): <input type="checkbox"/> Oxygen <input type="checkbox"/> Chronic Corticosteroid therapy <input type="checkbox"/> Bronchodilator <input type="checkbox"/> Diuretics			
<input type="checkbox"/> Prematurity Gestational age of < 34 weeks 6 days		AND <12 months at the start of the RSV season	
Plus one of the following conditions: <input type="checkbox"/> Congenital abnormality of airway <input type="checkbox"/> Severe neuromuscular disease			
<input type="checkbox"/> Patient ≤ 24 months of age and diagnosis of Congenital Heart Disease (Hemodynamically Significant) Plus one of the following conditions: <input type="checkbox"/> Moderate to Severe Pulmonary Hypertension <input type="checkbox"/> Receiving medication for CHD			
Other Medical Condition(s):			
RX INFORMATION			
<input type="checkbox"/> Expected date of first injection: Date ____/____/____			
<input type="checkbox"/> Injection already given?		<input type="checkbox"/> YES Date(s) ____/____/____ <input type="checkbox"/> NO	
Did the patient spend time in the NICU <input type="checkbox"/> No <input type="checkbox"/> Yes (provide NICU dose IF given _____)			
Note: Upon approval determination this information will be supplied to our preferred specialty vendor whom will contact you for the prescription and delivery information.			
SYNAGIS® (PALIVIZUMAB) <input type="checkbox"/> 50mg		<input type="checkbox"/> 100mg vials	
Sig: Inject 15 mg/kg IM one time per month.		Dispense Quantity: QS	
Sig: _____		Refill _____ months	
<input type="checkbox"/> Other _____			
PHYSICIAN INFORMATION			
Physician Name: _____		Physician Signature: _____	
Address: _____		Date: ____/____/____ NPI #: _____	
City: _____		State: ____ Zip: _____	
Phone Number: _____		Fax Number: _____	

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