



Prior Authorization Form
Synagis® (palivizumab)

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Patient Information

Patient's name
Cardholder's name
Patient's address
City, State, Zip:
Patient's phone #
Patient's ID#: DOB

Prescriber Information

Prescribing physician
Prescriber NPI#
Office address
City, State, Zip:
Office contact
Office # Fax#

Rx

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

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

Dispense Quantity (QS)

Refill months

Dispense as written

Substitution Allowed

Prescriber Signature

Date

Patient's Gestational Age:

Chronological Age:

Current Weight:

Date recorded:

Previous Injections? (including doses given in NICU)

Yes No

How many doses Dates given

Expected date of 1st or next injection:

Does the patient have any allergies? No Yes

DIAGNOSIS AND PATIENT HISTORY: (check all that apply)

Chronic Pulmonary Disease[CLD/BPD] Specify ICD9 code

Please attach supporting documentation (including pulmonary consults)

- a. Does patient have Bronchopulmonary Dysplasia [BPD]?
b. Does patient have Interstitial pulmonary fibrosis of prematurity?
c. Does patient have Wilson-Mikity Syndrome?
d. Does patient have chronic obstructive asthma?
e. Does patient have chronic bronchitis?
f. Does patient have bronchiolitis?
g. Other

Is patient receiving medical treatment? (check all that apply and provide dates)

Yes No

Oxygen, Date:

Corticosteroids, Date:

Bronchodilator, Date:

Diuretics, Date:

Congenital Heart Disease (747.0-745.4) Please specify ICD9 DX

Please attach supporting documentation (including latest cardiology consultations, echocardiograms/catherization records)

Diagnosis of Hemodynamically significant Congenital Heart Disease? Yes No

Diagnosis of Moderate-Severe Pulmonary Hypertension? Yes No

List medications currently used to control CHF

Congenital Abnormality of Respiratory System (748.3-748.4), Please specify ICD9

Severe Neuromuscular Disease that compromises mobilization of respiratory secretions, specify ICD9

Other diagnosis

PLEASE ONLY FILL OUT FOR GESTATIONAL AGE 32 TO LESS THAN 35 WEEKS AND UNDER 3 MONTHS OF AGE

Patients attends day care; Name of daycare Number of days per week

Siblings; Please list number of siblings and their age

FAX TO (888) 671-5285 YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL