



Please complete ALL information below and fax your request to 1-888-671-5285

Synagis® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if generic substitution is acceptable			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below: <input type="checkbox"/> Prophylaxis of respiratory syncytial virus (RSV) <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Clinical Information: Please document the patient's gestational age: _____ weeks, _____ days Select the patient's age at the start of the RSV season: <input type="checkbox"/> < 12 months <input type="checkbox"/> 12 to < 24 months <input type="checkbox"/> ≥ 24 months Select if Synagis is prescribed by or in consultation with one of the following specialists: <input type="checkbox"/> Infectious disease specialist <input type="checkbox"/> Pediatric cardiologist <input type="checkbox"/> Pediatric intensivist <input type="checkbox"/> Pediatric pulmonologist <input type="checkbox"/> Neonatologist <input type="checkbox"/> Neurologist Will Synagis be used for the prevention of serious lower respiratory tract infection caused by RSV during the RSV season for the patient's geographic region? <input type="checkbox"/> Yes <input type="checkbox"/> No					
For chronic lung disease (CLD) of prematurity, also answer the following: Did the patient receive greater than 21% oxygen supplementation for at least the first 28 days after birth? <input type="checkbox"/> Yes <input type="checkbox"/> No For patients at least 12 to < 24 months at the start of the RSV season, did the patient receive medical support (i.e., chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) within 6 months before the start of the second RSV season? <input type="checkbox"/> Yes <input type="checkbox"/> No					
For hemodynamically significant congenital heart disease, also answer the following: For patients < 12 months of age at the start of RSV season, select if the patient has the following: <input type="checkbox"/> Acyanotic heart failure <input type="checkbox"/> Receiving medication to control congestive heart failure <input type="checkbox"/> Patient will require a cardiac procedure <input type="checkbox"/> Moderate to severe pulmonary hypertension <input type="checkbox"/> Cyanotic heart defect For patients < 24 months, has the patient undergone or will the patient be undergoing a cardiac transplantation during the RSV season? <input type="checkbox"/> Yes <input type="checkbox"/> No					

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of FutureScripts. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. If you are not the intended recipient, please notify the sender immediately.

Office use only: Synagis_FSP_2017Aug-W



Synagis® Prior Authorization Request Form (Page 2 of 2)
DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

For pulmonary abnormality (e.g., pulmonary malformations, tracheoesophageal fistula, conditions requiring tracheostomy) or neuromuscular disorder (e.g., cerebral palsy), also answer the following:
For patients < 12 months of age at the start of RSV season, does the patient have impaired ability to clear secretions from the upper airway due to an ineffective cough? Yes No

For immunocompromised children, also answer the following:
Has the patient received or will receive a solid organ transplant, hematopoietic stem cell transplant, or chemotherapy during the RSV season? Yes No
Is the patient's lymphocyte count below the normal range for the patient's age? Yes No

For children with cystic fibrosis, also answer the following:
For patients < 12 months, is there clinical evidence of chronic lung disease and/or nutritional compromise (i.e., failure to thrive)? Yes No
For patients at least 12 months to < 24 months, does the patient have severe lung disease (previous hospitalization for pulmonary exacerbation in the first year of life, abnormalities on chest radiography or chest computed tomography that persist when stable) or weight for length < 10th percentile on pediatric growth chart? Yes No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.