

Do not use this form for buy and bill

Fax the completed form to Pharmacy Prior Authorization Department at 1-866-399-0929

Patient Information				
Last Name:		First Name:		Middle:
Address:			City:	State: Zip:
Daytime Phone:		Evening Phone:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Insurance Information (Attach copies of cards)				
Primary Insurance:			Secondary Insurance:	
ID #	Group #		ID #	Group #
City:		State:	City: State:	
Physician Information				
Name:			Specialty:	NPI:
Address:			City:	State: Zip:
Phone #:		Secure Fax #:		Office Contact:
Primary Diagnosis				
ICD-10 Code: _____				
<input type="checkbox"/> Preterm birth <input type="checkbox"/> Chronic lung disease of prematurity (bronchopulmonary dysplasia) <input type="checkbox"/> Congenital heart disease <input type="checkbox"/> Anatomic pulmonary abnormalities <input type="checkbox"/> Neuromuscular disorder <input type="checkbox"/> Profoundly immunocompromised <input type="checkbox"/> Cystic fibrosis <input type="checkbox"/> Other: _____				
Prescription Information				
MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Synagis (palivizumab)				
Clinical Information ***** Please submit supporting clinical documentation *****				
<input type="checkbox"/> INITIAL THERAPY <input type="checkbox"/> CONTINUATION OF THERAPY; Therapy start date: _____				
1. Has patient had a positive response to the prescribed therapy? <input type="checkbox"/> Yes: _____ <input type="checkbox"/> No <input type="checkbox"/> Not applicable 2. Is Synagis prescribed for prophylaxis of respiratory syncytial virus (RSV)? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Has patient received more than 5 doses of Synagis during the current RSV season? <input type="checkbox"/> Yes: _____ doses <input type="checkbox"/> No a. If yes, did patient undergo cardio-pulmonary bypass during the current RSV season? <input type="checkbox"/> Yes <input type="checkbox"/> No 4. If requests for RSV prophylaxis extend beyond the identified season duration for Florida or beyond September through May for the remainder of the U.S., is there medical justification supporting use? <input type="checkbox"/> Yes **Submit documentation** <input type="checkbox"/> No 5. Has patient been hospitalized with RSV disease during the current RSV season? <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Please document patient's current weight: _____ kg				
Complete this section ONLY if the patient is initiating therapy:				
7. Is patient an Alaska native or American Indian? <input type="checkbox"/> Yes <input type="checkbox"/> No				
8. Will patient be profoundly immunocompromised during the RSV season (e.g., due to solid organ or hematopoietic stem cell transplantation, chemotherapy, severe combined immunodeficiency, chronic granulomatous disease)? <input type="checkbox"/> Yes <input type="checkbox"/> No				
9. If preterm birth or chronic lung disease of prematurity, please document patient's gestational age: _____ weeks _____ days				
10. If chronic lung disease of prematurity,				
a. Did patient require > 21% oxygen for at least 28 days after birth? <input type="checkbox"/> Yes <input type="checkbox"/> No				
b. Has patient required any of the following within 6 months of the start of RSV season? <input type="checkbox"/> Yes **Mark all that apply** <input type="checkbox"/> No <input type="checkbox"/> Supplemental oxygen <input type="checkbox"/> Chronic corticosteroid therapy <input type="checkbox"/> Diuretic therapy				
11. If congenital heart disease, does any of the following apply to patient? <input type="checkbox"/> Yes **Mark all that apply** <input type="checkbox"/> No <input type="checkbox"/> Acyanotic heart disease <input type="checkbox"/> Medication to control congestive heart failure required <input type="checkbox"/> Cardiac surgical procedure required <input type="checkbox"/> Moderate to severe pulmonary hypertension <input type="checkbox"/> Cyanotic heart defect and RSV prophylaxis is recommended by pediatric cardiologist <input type="checkbox"/> Undergoing cardiac transplantation or cardio-pulmonary bypass during the current RSV season				

Please continue to page 2.

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Patient Name: _____ **DOB:** _____

12. **If anatomic pulmonary abnormalities or neuromuscular disorder**, does patient have impaired ability to clear secretions from the upper airways (e.g., due to ineffective cough)? Yes No

13. **If cystic fibrosis,**

- a. Does patient have manifestations of severe lung disease (e.g., previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest radiography or chest computed tomography that persist when stable)? Yes No
- b. Is patient's weight for length < 10th percentile? Yes No
- c. Is there clinical evidence of nutritional compromise? Yes No
- d. Has patient been diagnosed with chronic lung disease of prematurity? Yes No

Complete this section ONLY for indications other than those listed above:

14. Has patient tried and failed, or is contraindicated to, accepted standards of care? Yes No

If yes, submit documentation and answer the following:

- a. Please list all previous therapies: _____
- b. Was patient adherent to previously tried therapies? Yes No No, patient intolerant to drug

Physician's Signature _____ **Date:** _____ DAW