coordinated care

Phone: 1-800-511-5144 Fax: 1-877-541-1503

Palivizumab (Synagis)
Prior Authorization Form/Prescription

Date: _____ Date Medication Required: _____
Ship to: ❍ Physician ❍ Patient's Home ❍ Other _____

Patient Information

Last Name:	First Name:	Middle:	DOB: ____/____/_____
Address:	City:	State:	Zip:
Daytime Phone:	Evening Phone:	Sex: ☐ Male	☐ 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: _____

☐Preterm birth ☐Chronic lung disease of prematurity (bronchopulmonary dysplasia) ☐Congenital heart disease
☐Anatomic pulmonary abnormalities ☐Neuromuscular disorder ☐Profoundly immunocompromised ☐Cystic fibrosis
☐Other: _____

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Synagis (palivizumab)				

Clinical Information

***** *Please submit supporting clinical documentation* *****

☐**INITIAL THERAPY** ☐**CONTINUATION OF THERAPY;** Therapy start date: _____

1. Has patient had a positive response to the prescribed therapy? ☐Yes ☐No ☐Not applicable
2. Is Synagis prescribed for prophylaxis of respiratory syncytial virus (RSV)? ☐Yes ☐No
3. Has patient received more than 5 doses of Synagis during the current RSV season? ☐Yes: _____ doses ☐No
   a. **If yes**, did patient undergo cardiac transplantation or cardio-pulmonary bypass during the current RSV season? ☐Yes ☐No
4. Has patient been hospitalized with RSV disease during the current RSV season? ☐Yes ☐No
5. Please document patient's current weight: _____ kg

Complete this section ONLY if the patient is <u>initiating</u> therapy OR if the patient is <u>new</u> to this health plan:

6. Is patient an Alaska native or American Indian? ☐Yes ☐No
7. 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)? ☐Yes ☐No
8. **If preterm birth or chronic lung disease of prematurity**, please document patient's gestational age: _____ weeks _____ days
9. **If chronic lung disease of prematurity,**
   a. Did patient require > 21% oxygen for at least 28 days after birth? ☐Yes ☐No
   b. Has patient required any of the following within 6 months of the start of RSV season? ☐Yes ***Mark all that apply*** ☐No
      ☐Supplemental oxygen ☐Chronic systemic corticosteroid therapy ☐Diuretic therapy
10. **If congenital heart disease,** does any of the following apply to patient? ☐Yes ***Mark all that apply*** ☐No
    ☐Acyanotic heart disease
    ☐Cyanotic heart defect and RSV prophylaxis is recommended by pediatric cardiologist
    ☐Medication to control congestive heart failure required
    ☐Cardiac surgical procedure required
    ☐Moderate to severe pulmonary hypertension
    ☐Undergoing cardiac transplantation or cardio-pulmonary bypass during the current RSV season

Please continue to page 2.

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Patient Name:
_____**DOB:**_____

11. **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
12. **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 <u>other</u> than those listed above:

13. 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