

MASSACHUSETTS STANDARD FORM FOR SYNAGIS® PRIOR AUTHORIZATION REQUESTS

**Some plans might not accept this form for Medicare or Medicaid requests.*

A. Destination	
Health Plan or Prescription Plan Name:	
Health Plan Phone:	Health Plan Fax:

B. Patient Information		
Patient Name:	DOB:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____
Member ID #:		

C. Prescriber Information	
Prescribing Clinician:	Phone #:
Specialty:	Secure Fax #:
NPI #:	DEA #:
Prescriber Point of Contact (POC) Name (if different than prescriber):	
POC Phone #:	POC Secure Fax #:
POC Email (not required):	
Prescribing Clinician or Authorized Representative Signature:	
Date:	

D. Medication Information — SYNAGIS® (palivizumab)
Check if Expedited Review/Urgent Request:
<input type="checkbox"/> (In checking this box, I attest to the fact that this request meets the definition and criteria for expedited review and is an urgent request.)
Is the patient currently being treated with the drug requested? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, date started: _____ Date of last dose received: _____ Number of doses received: _____
Number of doses requested: _____

E. Patient Clinical Information
Primary Diagnosis Related to Medication Request:
ICD Code(s):
Gestational age: # weeks: _____ # days: _____
Birth weight: _____ Current weight: _____ Date current weight recorded: _____
Pertinent Concurrent Medications:
Allergies:

Clinical Conditions (2014 AAP Committee on Infectious Disease and Bronchiolitis Guidelines)

Chronic Lung Disease (CLD)	CLD of prematurity defined as gestational age \leq 31 weeks, 6 days, AND requirement for 21% oxygen for at least the first 28 days after birth <input type="checkbox"/> <12 months of age with CLD <input type="checkbox"/> 12–24 months of age with CLD AND continues to require medical support during the 6-month period before second RSV season AND <input type="checkbox"/> Supplemental oxygen (dates): _____ <input type="checkbox"/> Diuretic therapy (drugs/dates): _____ <input type="checkbox"/> Chronic corticosteroids (drugs/dates): _____ <input type="checkbox"/> Other _____ Chronic Respiratory Disease arising in the perinatal period: <input type="checkbox"/> Wilson-Mikity Syndrome (P27.0) <input type="checkbox"/> Bronchopulmonary Dysplasia originating in the perinatal period (P27.1) <input type="checkbox"/> Other chronic respiratory disease originating in the perinatal period (P27.8) Congenital Abnormality of the Lungs: _____ _____
Congenital Heart Disease (CHD)	<input type="checkbox"/> <12 months of age at start of season with hemodynamically significant CHD such as: <input type="checkbox"/> Acyanotic heart disease and receiving medication to control congestive heart failure and surgery to correct (drugs/dates): _____ (surgery date): _____ <input type="checkbox"/> Moderate to severe pulmonary hypertension <input type="checkbox"/> Other (describe): _____ <input type="checkbox"/> 12–24 months of age undergoing cardiac transplant during RSV season (date of planned surgery): _____ <input type="checkbox"/> Cyanotic Heart Disease — Diagnosis: _____
Airway/Neuromuscular Conditions	<input type="checkbox"/> <12 months of age at start of season and compromised handling of secretions AND due to: <input type="checkbox"/> Significant abnormality of the airway (attach clinical notes) <input type="checkbox"/> Neuromuscular condition (attach clinical notes)
Prematurity	<input type="checkbox"/> \leq GA 28 weeks, 6 days AND <12 months at start of season
Other medical conditions or history	<input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Down's Syndrome <input type="checkbox"/> Immunocompromised <input type="checkbox"/> Describe other relevant medical history: _____ _____ _____

Complete this section for Professionally Administered Medications (including Buy and Bill)

Start Date:	End Date:
Servicing Prescriber/Facility Name:	<input type="checkbox"/> Same as Prescribing Clinician
Servicing Provider/Facility Address:	
Servicing Provider NPI/Tax ID #:	
Name of Billing Provider:	
Billing Provider NPI #:	
Is this a request for reauthorization? <input type="checkbox"/> Yes <input type="checkbox"/> No	
CPT Code: _____ # of Visits: _____ J Code: _____ # of Units: _____	

Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers may attach any additional data relevant to medical necessity criteria.