

MASSACHUSETTS STANDARD FORM FOR SYNAGIS® PRIOR AUTHORIZATION REQUESTS

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

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| 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: | |

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| 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: _____ |

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| E. Patient Clinical Information |
| Primary Diagnosis Related to Mediation 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 Mediations (including Buy and Bill) | |
| Start Date: | End Date: |
| Servicing Prescriber/Facility Name: | <input type="checkbox"/> Same as Prescribing Clinician |
| Servicing Prescriber/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.*