

Synagis® (Palivizumab) Authorization Request

Complete form in its entirety and fax to the UM Department at 1-800-823-5520 or contact 1-888-831-2246.

Click on grey boxes to type		Request Date: / /	
<input type="checkbox"/> Initial Authorization Request		<input type="checkbox"/> Re-Authorization Request; List Prior Auth Ref#:	
1. PATIENT INFORMATION			
Last Name		First Name	
ID#		DOB	
Address		City	
State / ZIP		Phone	
Date	Primary Diagnosis		Weight / Date /
2. PHYSICIAN INFORMATION			
Last Name		First Name	
DEA/ NPI #		Tax ID	
Address		City	
State		ZIP	
Phone	Fax	Contact's Name	Phone
3. MEDICATION INFORMATION – This section serves as the active prescription – signature required.			
Drug Requested Synagis CPT 90378		Strength / Dose	
Direction for Use (SIG)		Number of Requested Injections	
Medication will be supplied by		Tax ID#	Contact: Phone: Fax:
Date patient is scheduled to be treated (need by date) / /		Service From Date / /	Service Thru Date / /
Place of Service <input type="checkbox"/> MD Office <input type="checkbox"/> Patient's Home <input type="checkbox"/> Other:		If place of service is home , please specify reason or justification Home Health Agency Name	
Prescriber's Signature		Date / /	
4. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY			
NOTE: To avoid delays, please complete this form in its entirety. Incomplete forms that are missing pertinent information will be pended. If indicated, please provide ALL supporting lab results, progress notes, etc.			
I. Respiratory Syncytial Virus (RSV)			
1. What is patient's gestational age: weeks and days			
2. Did patient receive any Synagis injections this season? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate when and how many?			
II. Within the first year of life			
<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Was patient born at 28 or less weeks of gestation (up to and including 28 weeks, 6 days) and is less than 12 months of age at the start of RSV season?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Was patient born between 29 weeks 0 days to 31 weeks 6 days of gestation and is less than 6 months of age at the start of RSV season?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Was patient born between 32 weeks 0 days through 34 weeks, 6 days of gestation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Does patient have chronic lung disease [formerly designated Bronchopulmonary Dysplasia (BPD)] and was treated with oxygen, steroids, bronchodilators, or diuretics within the previous 6 months before the start of RSV season? (Note: Asthma, reactive airway disease, and cystic fibrosis do not meet the definition of chronic lung disease.)		
<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Does patient have hemodynamically significant congenital heart disease? a. If yes, please specify type of heart disease. <input type="checkbox"/> Yes <input type="checkbox"/> No a. Has it been surgically corrected? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Is there associated Congestive Heart Failure? <input type="checkbox"/> Yes <input type="checkbox"/> No c. Is there any Pulmonary Hypertension? <input type="checkbox"/> Yes <input type="checkbox"/> No d. Has the infant required medication or oxygen within previous 6 months?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	6. Was patient born before 35 weeks of gestation with congenital abnormalities of the airway? a. If yes, please specify diagnosis.		
<input type="checkbox"/> Yes <input type="checkbox"/> No	7. Was patient born before 35 weeks of gestation with a neuromuscular condition that compromises handling of respiratory secretions? a. If yes, please specify diagnosis.		
II. Within the first year of life - One additional dose of Synagis			
<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Is patient currently being treated with Synagis that was approved as medically appropriate and is undergoing cardiopulmonary bypass for surgical procedures due to documented reduction in serum levels post-bypass?		
III. Within the second year of life			
<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Does patient have chronic lung disease [formerly designated Bronchopulmonary Dysplasia (BPD)] and was treated with oxygen, steroids, bronchodilators, or diuretics within the previous 6 months before the start of RSV season? (Note: Asthma, reactive airway disease, and cystic fibrosis do not meet the definition of chronic lung disease.)		
<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Does patient have hemodynamically significant congenital heart disease? 3. If yes, please specify type of heart disease. <input type="checkbox"/> Yes <input type="checkbox"/> No a. Has it been surgically corrected? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Is there associated Congestive Heart Failure? <input type="checkbox"/> Yes <input type="checkbox"/> No c. Is there any Pulmonary Hypertension? <input type="checkbox"/> Yes <input type="checkbox"/> No d. Has the infant required medication or oxygen within previous 6 months?		
Other Use(s) or Information (This will not be reviewed unless all supporting documentation, labs, NICU discharge, etc., are attached.)			