SYNAGIS® (palivizumab)
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

ONLY the provider may complete this form. This form is for prospective, concurrent, and retrospective reviews.

Incomplete forms will be returned for additional information. The following documentation is required for preauthorization consideration. For formulary information and to download additional forms, please visit www.bcchpil.com

PATIENT AND INSURANCE INFORMATION **Today's Date:** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
BCBS ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis – ICD code plus description:

Medication Requested: Strength:

***Your request will be reviewed for the generic equivalent unless you specify brand is required.**

Dosing Schedule: Quantity per Month:

GESTATIONAL AGE AT BIRTH: _____weeks _____ days | **Patient's Height:** _____cm | **Patient's Weight:** _____ kg

1. Is the patient currently treated with the requested medication? ☐ Yes ☐ No
   If yes, when was treatment with the requested medication started? _____
2. Has the patient received Synagis for the current RSV season? ☐ Yes ☐ No
   If yes, provide number of doses received: _____ and date(s) given: _____
   If no, provide date first dose will be given: _____
3. Please provide the patient's current RSV season: _____
4. Will the requested drug be used during the patient's current RSV season? ☐ Yes ☐ No
5. Is the requested agent being prescribed for the prevention of serious lower respiratory tract disease caused by respiratory syncytial virus? ☐ Yes ☐ No
6. Has the patient been hospitalized for RSV infection during the current RSV season? ☐ Yes ☐ No
7. Does the patient have chronic lung disease (CLD) of prematurity? ☐ Yes ☐ No
   If yes, did the patient require supplemental oxygen for at least the first 28 days after birth? ☐ Yes ☐ No
   Has the patient required medical support for CLD in the 6 months prior to the current RSV season? ☐ Yes ☐ No
   If yes, please explain: _____
8. Is the patient profoundly immunocompromised during the current RSV season? ☐ Yes ☐ No
   If yes, please explain: _____
9. Does the patient have congenital abnormalities of the airway or a neuromuscular condition impairing ability to clear respiratory secretions? ☐ Yes ☐ No
10. Does the patient have hemodynamically significant congenital heart disease? ☐ Yes ☐ No
11. Will the patient undergo cardiac transplantation during the current RSV season? ☐ Yes ☐ No
12. Is the patient an infant with lesions adequately corrected by surgery but continues to require medication for congestive heart failure? ☐ Yes ☐ No

Please continue on page 2.

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):

13. Does the patient have acyanotic heart disease, is receiving medication to control congestive heart failure, and will require cardiac surgical procedures? ☐ Yes ☐ No
14. Does the patient have moderate-to-severe pulmonary hypertension? ☐ Yes ☐ No
15. Does the patient have mild cardiomyopathy AND is currently receiving medical therapy for the condition? ☐ Yes ☐ No
16. Does the patient have cyanotic heart disease? ☐ Yes ☐ No
    If yes, is the prescriber a pediatric cardiologist or has consulted with a pediatric cardiologist? ☐ Yes ☐ No
17. Does the patient have cystic fibrosis? ☐ Yes ☐ No

    If yes, does the patient have any of the following? **Check all that apply.**

    ☐ Chronic lung disease

    ☐ Manifestations of severe lung disease

    Please explain: _____

    ☐ Nutritional compromise

    ☐ Weight for length <10th percentile

18. Please list all reasons for selecting the requested **medication, dosing schedule, and quantity** over alternatives (e.g., contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried). _____

    _____

19. Please list all other medications the patient is **currently taking** for treatment of this diagnosis. _____

    _____

    _____

20. Please list all medications the patient has **previously tried and failed** for treatment of this diagnosis. (Please specify if the patient has tried brand-name products, generic products, or over-the-counter products.)

    _____ Date(s): _____ _____ Date(s): _____

    _____ Date(s): _____ _____ Date(s): _____

    _____ Date(s): _____ _____ Date(s): _____

Please fax or mail this form to:
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c/o Prime Therapeutics LLC, Clinical Review Department
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Eagan, Minnesota 55121

TOLL FREE
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