

Synagis Prior Authorization/Statement of Medical Necessity/Order Form

BCBS
Blue Salud
Lovelace
Molina
Presbyterian
United Health
Other
Child's Wt.(Current Kg) _____

Patient Name		Gender:	DOB:	Today's Date:
Insurance ID/SS#:			Parent/Guardian Name	
Address:				
Phone:			Phone 2:	
Insurance:			Insurance 2:	
Provider's Name				
Provider's Address				
Provider's Phone:			Provider's Fax:	
NICU Graduate: Yes _____ No _____ Unknown _____			Date of first dose:	Location of first dose:
Gestational Age: _____ 28 wks, 6 days _____ 29 wks, 0 days to 31 wks, 6 days _____ 32 wks, 0 days to 34 wks, 6 days				
ICD Code: _____ 765.10 Premature _____ Other:				

Please check the one criteria that best applies to this patient: (One of the following criteria must be checked)

1	<24 months old (as of November 15) and with hemodynamically significant congenital heart disease (CHD) specify type:			
2	<24 months old (as of November 15) and with chronic lung disease (CLD) of prematurity requiring oxygen or pulmonary medication in the last six months (specify below)			
3	<24 months old (as of November 15) and with severe immunodeficiency (specify type)			
4	<12 months old (as of November 15) and born at 28 wks, 6 days gestation or less			
5	<6 months old (as of November 15) and born 29 wks, 0 days to 31 wks, 6 days gestation			
6	<90 days of age (as of November 15) and born at 32 wks, 0 days to 34 wks, 6 days gestation and with 1 or more risk factors:			
6a	Childcare attendance	Date Starting:	Name of Childcare:	Phone:
6b	Sibling(s) in home under 5 years		Ages:	
7	Severe Neuromuscular disease			
8	Congenital abnormality of the airway			

Please list any other pertinent information, including medical records that document CLD or CHD in 32 to 35 weeks gestation, other risk factors, and specialists involved in the care of this patient

STATEMENT OF MEDICAL NECESSITY

I hereby certify that the above services are medically necessary and are authorized by me. This patient is under my care and is in need of the services listed.

Molina/BCBS/Presbyterian Prescription Information

- Administer Synagis (Palivizumab) 15 mg/kg IM every month (q28-31 days) for duration of RSV season as determined by the patient's health insurance plan. Epinephrine 1:10,000, 0.01mg/kg for anaphylaxis as directed. Upon parent's choice of agency, home nursing to be arranged by member's health insurance agency.

Provider Signature: X **Date:**

Lovelace (McKesson) Prescription Information

- Synagis (Palivizumab) Kit 50mg and/or 100mg., vials, needles & syringes.
Sig: Inject 15mg/kg. IM every 28 days, Refill x 5
- Deliver Synagis (Palivizumab) to provider's office for administration as above.

Provider Signature: X **Date:**

INDIVIDUAL ORDERS:

- Administer Synagis (Palivizumab 15 mg/kg IM every month (q28-31 days) for duration of RSV season as determined by patient's health insurance plan.
- Epinephrine 1:10,000, 0.01mg/kg IM for anaphylaxis as directed
- Deliver Synagis (Palivizumab) to provider's office for administration as above.
- Arrange home health care agency to administer Synagis (Palivizumab).

Provider Signature: X **Date:**

APPROVED: Authorization#	Authorization by:	Date:
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DENIED: