SYNAGIS® PALIVIZUMAB

Neighborhood Health Plan OF RHODE ISLAND™

option care™

SYNAGIS®PRIOR AUTHORIZATION - PATIENT INFORMATION

FAX COMPLETED FORM TO 401-435-3319

RESPIRATORY SYNCYTIAL VIRUS (RSV) PROPHYLAXIS STATEMENT OF MEDICAL NECESSITY – CLINICAL INFORMATION

Gestational Age (weeks) _____ Birth Weight (kg/lbs) _____
Most Recent Weight (kg/lbs) _____ Date Recorded _____

ONE OF THE FOLLOWING CRITERIA NEEDS TO BE MET TO QUALIFY FOR SYNAGIS®.
NOTE: Reactive Airway is NOT a qualifying diagnosis. ***Please check all that apply:***

Child will be 12 months or younger on November 1, 2015 and at least one of the following:

- ❑ **Child was born at less than 29 weeks, 0 days gestation**; OR
- ❑ **Child was born at less than 32 weeks, 0 days gestation and developed chronic lung disease (CLD) of prematurity defined as requiring supplemental (>21%) oxygen for at least the first 28 days after birth;** OR
- ❑ **Child with neuromuscular disease or congenital anomaly that impairs ability to clear secretions from upper airway due to ineffective cough;** OR
- ❑ **Child has hemodynamically significant heart disease and at least one of the following** (please check all that apply):
  - ❑ Congestive heart failure
  - ❑ Oxygen requirement
  - ❑ Pulmonary hypertension
  - ❑ Neuromuscular disease
  - ❑ Cardiac medication
  - ❑ Cyanotic defects
  - ❑ Anticipated heart surgery during RSV season;
  - ❑ Anatomic pulmonary abnormalities

Child has at least one of the following (please check all that apply):

- ❑ Severely immunocompromised
- ❑ Chemotherapy
- ❑ Organ transplant
- ❑ hematopoietic stem cell transplant
- ❑ Cystic fibrosis AND respiratory failure
- ❑ Cystic fibrosis AND malnutrition; OR

Child will be 12 to 24 months on November 1, 2015 and at least one of the following:

- ❑ **Child was born at less than 32 weeks, 0 days gestation and CLD of prematurity defined as requiring supplemental (>21%) oxygen for at least 28 days after birth and has required supplemental oxygen, diuretics or corticosteroid in the last 6 months;** or
- ❑ **Child has at least one of the following** (please check all that apply):
  - ❑ Severely immunocompromised
  - ❑ Organ transplant
  - ❑ Chemotherapy
  - ❑ Cystic fibrosis AND severe lung disease
  - ❑ Cystic fibrosis AND weight for length < 10th percentile; OR

Other Rationale: Are there other medical reasons or diagnoses that explain why this child should receive Synagis prophylaxis? If so, please list: _____

(Note: Reactive Airway is not a qualifying diagnosis.)

Additional Information Required for Processing:

A. NICU History: ❑ Yes ❑ No Please attach the NICU Discharge Summary

B. Was there an NICU/Hospital dose administered? ❑ Yes ❑ No If YES, Date/Dose Given:_____

Expected Date of First/Next Injection:_____

❑ Synagis® (palivizumab) 50 and/or 100 mg vials
Sig: Administer as directed and inject 15 mg/kg IM one time per month
Quantity: QS for weight based dosing
Injection Dates: _____, 2015 thru _____, 2016

❑ Epinephrine 1:1000 amp. Sig: Inject 0.01mg/kg as directed

❑ Other Medications:_____

❑ Known Allergies: _____

Prescriber's Signature: _____ Date: _____

RX: Refills Monthly Nov 1, 2015 to March 31, 2016

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Last Name	First Name		Middle Initial
Street Address	**City**	**State**	**Zip Code**
Day Telephone (+Area Code)	**Evening Telephone (+Area Code)**		
			❑ M ❑ F
Date of Birth	**Social Security Number**		**Sex**

Parent/Guardian

INSURANCE INFORMATION

Include copies of the patient's insurance cards and drug benefit cards (front and back) to expedite benefit clearance.

Primary Insurance	Secondary Insurance
Cardholder Name & Social Security Number (If Not Patient)	Cardholder Name & Social Security Number (If Not Patient)
ID Number	ID Number
Authorization Number/Units	Authorization Number/Units
Authorized by	Authorized by
Patient Responsibility	Verified by Date/Time

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PHYSICIAN INFORMATION

Prescriber's Name	Hospital/Clinic	Office Contact
Address	**City/State/Zip**	**Telephone Number (+Area Code)**
Prescriber's Group Name		**Fax Number (+Area Code)**
Prescriber's License Number	**DEA Number**	**NPI Number**

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FOR NHPRI USE ONLY:

Auth#: _____ **Approved By:** _____

Date: _____ **# Injections Approved** _____

Start Date: _____ **Thru Date:** _____

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