

Synagis Prior Authorization/Statement of Medical Necessity/Order Form

BCBS
Lovelace
Molina
Presbyterian
Other

Insurance ID/SS#		DOB:	Today's Date:
Patient Name		Gender:	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: (see discharge summary)
Gestational Age: _____ Born <28 wks _____ 28 to 32 wks _____ 32 to < 35 wks			
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 1) and with hemodynamically significant congenital heart disease (CHD) (specify type)			
2	<24 months old (as of November 1) 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 1) and with severe immunodeficiency (specify type)			
4	<12 months old (as of November 1) and born at 28 weeks gestation or less			
5	<6 months old (as of November 1) and born at 29-32 weeks gestation			
6	<6 months old (as of November 1) and born at 32 to < 35 weeks gestation and with 2 or more risk factors:			
	6a	Childcare attendance	6d	Wood burning stove/fireplace
	6b	School aged siblings	6e	Severe neuromuscular disease
	6c	Smokers in the home	6f	Congenital abnormality of 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. The patient is under my care and is in need of the services listed.

Molina/BCBS/Presbyterian Prescription Information	
<input type="checkbox"/> 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 IM for anaphylaxis directed. Upon parent's choice of agency, home nursing to be arranged by member's health insurance agency.	
Provider signature: _____	Date: _____
Lovelace (McKesson) Prescription Information	
<input type="checkbox"/> Synagis (Palivizumab) kit 50mg and/or 100mg vials, needles & syringes. Sig: Inj 15mg/kg IM every 28 days	
Provider Signature: _____	Date: _____

INDIVIDUAL ORDERS:

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 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: _____ Date: _____

APPROVED: Authorization #	Authorization by:	Date:
DENIED:		

Guardian Name:

Guardian Home #:

Presbyterian: PHP Pharmacy 505-923-5757
 Lovelace Health Plan: 505-262-7814 or
 Molina HealthCare of New Mexico:
 BCBS:

FAX 505-923-5540 or 800-724-6953
FAX 505-262-7390
FAX 866-472-4578
FAX 505-816-3608