

Synagis Prior Authorization/Statement of Medical Necessity/Order Form

BCBS Lovelace Molina Presbyterian Other _____

Patient Name:		DOB:	Today's Date:
Insurance ID/SS#:		Parent's 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 ___ 28-32 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 factor, 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:		

BCBS: Lovelace Health Plan: 505-262-7814 or 800-877-7526 ext. 27814 Molina Health Care of New Mexico: Presbyterian: PHP Pharmacy: 505-923-5757	FAX 505-816-3608 FAX 505-262-7390 FAX 505-348-0299 FAX 505-923-5540 or 800-724-6953
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Guardian Name: _____

Guardian Home #: _____