

**Synagis® (palivizumab)**

Complete form in its entirety and fax to the UM Call Center at (404) 848-2448

Request Date:     /     /	<input type="checkbox"/> <b>Initial Authorization Request</b>	<input type="checkbox"/> <b>Subsequent Request</b>
<input type="checkbox"/> Medication(s) is to be dispensed, delivered, and managed by Precision Rx Specialty Solutions (800-824-2642) FAX		

Member Name:	Date of Birth: /     /
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Insurance Identification Number:	Member Phone Number:
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Primary Diagnosis:	ICD-9 Code(s):	Member's Weight _____ <input type="checkbox"/> (lbs) <input type="checkbox"/> (kg)
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Ordering Provider Name & Specialty:	Provider ID Number:
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Office Address:
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Office Phone Number:	Office Fax Number:
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Servicing Provider Name & Specialty (If different than Ordering Provider):	Provider ID Number:
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Office Address:
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Office Phone Number:	Office Fax Number:
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Place of Service: <input type="checkbox"/> Home <input type="checkbox"/> Office <input type="checkbox"/> Dialysis Center <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Ambulatory Infusion <input type="checkbox"/> Ambulatory Infusion Center <input type="checkbox"/> Other: _____
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HCPCS Code/Drug Name <input type="checkbox"/> <b>90378 Synagis</b>	Dose to be administered: _____ ( mg/kg)
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When did the member first start this drug? /     /	Frequency (Days, Wks, Months) _____
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Duration: _____ (Weeks)	Start Date For This Request: /     /	End Date For This Request: /     /
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**1. CLINICAL: CHECK ALL BOXES THAT APPLY TO THE MEMBER**

NOTE: **To avoid delays**, please complete this form in its entirety. Incomplete forms that are missing pertinent information will be pended.  
If indicated, please provide **ALL** supporting lab results, progress notes, etc.

**Prevention of Respiratory Syncytial Virus (RSV)**

What is pt's gestational age: \_\_\_\_\_ weeks and \_\_\_\_\_ days

Pt's birth weight: \_\_\_\_\_ Pt's current weight: \_\_\_\_\_ Date Weighed: \_\_\_\_\_

Did pt receive any doses of Synagis while in the hospital?  Yes (If yes how many?) \_\_\_\_\_  No

**Number of Synagis doses requested?** \_\_\_\_\_

**PreDetermination of Medical Benefits**

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**APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY (Continued)**

**Within the first year of life**

- Yes  No Was pt born at 28, or less, weeks of gestation and is less than 12 months of age at the start of RSV season?
- Yes  No Was pt born between 29 to 32 weeks of gestation and is less than 6 months of age at the start of RSV season?
- Yes  No Does pt have chronic lung disease [formerly designated Bronchopulmonary Dysplasia (BPD)] and was treated with oxygen, steroids, bronchodilators, or diuretics within the previous 6 months before the start of RSV season? (Note: Asthma, reactive airway disease, and cystic fibrosis do not meet the definition of chronic lung disease.)
- Yes  No Does pt have hemodynamically significant cyanotic or acyanotic congenital heart disease, for example is pt receiving medication for congestive heart failure, or for moderate to severe pulmonary hypertension?
- Yes  No Was pt born before 35 weeks of gestation with congenital abnormalities of the airway?
- Yes  No Was pt born before 35 weeks of gestation with a neuromuscular condition that compromises handling of respiratory secretions?
- Yes  No Was pt born between 32 and 35 weeks of gestation (beginning 32 weeks, 0 day through 34 weeks, 6 days) AND
  - Yes  No Is pt less than 3 months of age at the start of RSV season? AND
  - Yes  No Is pt less than 90 days old at the time of dosing? AND
  - Yes  No Does pt attend group child care, defined as a home or facility where care is provided along with at least one other infant or young child? OR
  - Yes  No Does pt have siblings or other children living in the household who are less than 5 years of age?

**Within the first year of life - One additional dose of Synagis**

- Yes  No Is pt currently being treated with Synagis that was approved as medically appropriate and is undergoing cardiopulmonary bypass for surgical procedures due to documented reduction in serum levels post-bypass?

**Within the second year of life**

- Yes  No Does pt have chronic lung disease [formerly designated Bronchopulmonary Dysplasia (BPD)] and was treated with oxygen, steroids, bronchodilators, or diuretics within the previous 6 months before the start of RSV season? (Note: Asthma, reactive airway disease, and cystic fibrosis do not meet the definition of chronic lung disease.)
- Yes  No Does pt have hemodynamically significant cyanotic or acyanotic congenital heart disease, for example is pt receiving medication for congestive heart failure, or for moderate to severe pulmonary hypertension?

**Other Use(s)** (This will not be reviewed unless all supporting evidence/documentation, labs, etc., are attached.)

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**2. PHYSICIAN SIGNATURE**

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**Prescriber Signature**

**Date**

Prior Authorization is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

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Medical Policy Reference can be found at: [www.bcbsga.com](http://www.bcbsga.com)