

- Request is for five (5) doses of palivizumab (Synagis®) within the RSV season during the first year of life
 - Born at 28, or less, weeks of gestation (up to and including 28 weeks, 6 days) and less than 12 months of age at the start of the RSV season
 - Born at 29 to 32 weeks gestation (beginning 29 weeks, 0 days through 31 weeks, 6 days) and less than 6 months of age at the start of the RSV season
 - Individual has chronic lung disease (CLD) [formerly designated Bronchopulmonary Dysplasia (BPD)]
 - The lung disease is **NOT** asthma, reactive airway disease or cystic fibrosis
 - Individual has required medical treatment within six months before the start of the RSV season with oxygen, steroids, bronchodilators or diuretics
 - Other: _____
 - Individual has hemodynamically significant (for example, but not limited to, receiving medication for congestive heart failure or moderate to severe pulmonary hypertension) cyanotic or acyanotic congenital heart disease (CHD)
 - Individual has congenital abnormalities of the airway or a neuromuscular condition that compromises the handling of respiratory secretions
 - Other: _____

- Request is for five (5) doses of palivizumab (Synagis®) within the RSV season during the second year of life
 - Individual has chronic lung disease (CLD) [formerly designated Bronchopulmonary Dysplasia (BPD)]
 - The lung disease is **NOT** asthma, reactive airway disease or cystic fibrosis
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 - Individual has hemodynamically significant (for example, but not limited to, receiving medication for congestive heart failure or moderate to severe pulmonary hypertension) cyanotic or acyanotic congenital heart disease (CHD)
 - Individual has congenital abnormalities of the airway or a neuromuscular condition that compromises the handling of respiratory secretions
 - Other: _____

Request is for an additional dose of palivizumab (Synagis®) for a child in an approved course of treatment who undergo cardiopulmonary bypass for surgical procedures due to documented reduction in serum levels post-bypass

(2) Other Use(s) (Please submit all supporting documents including labs, progress notes, imaging, etc., for review.)

This request is being submitted:

- Pre-Claim
- Post-Claim. If checked, please attach the claim or indicate the claim number _____

I attest the information provided is true and accurate to the best of my knowledge. I understand that the health plan or its designees may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

 Name and Title of Provider or Provider Representative Completing Form and Attestation (Please Print)*

 Date

***The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted.**

Anthem UM Services, Inc., a separate company, is the licensed utilization review agent that performs utilization management services on behalf of your health benefit plan or the administrator of your health benefit plan.