MASSACHUSETTS STANDARD FORM FOR SYNAGIS® PRIOR AUTHORIZATION REQUESTS

*Some plans might not accept this form for Medicare or Medicaid requests.

A. Destination					
Health Plan or Prescription Plan Name:					
Health Plan Phone:	He		Health Plan Fax:		
B. Patient Information					
Patient Name:	DOB:		Gender: Male Female Other:		
Member ID #:					
C. Prescriber Information					
escribing Clinician:		Phone #:			
Specialty:	S		Secure Fax #:		
NPI #:	[DEA #:			
Prescriber Point of Contact (POC) Name (if different than prescriber):					
Phone #:		POC Secure Fax #:			
POC Email (not required):					
Prescribing Clinician or Authorized Representative Signature:					
Date:					
D. Medication Information — SYNAGIS® (palivizumab)					
Check if Expedited Review/Urgent Request: (In checking this box, I attest to the fact that this request meets the definition and criteria for expedited review and is an urgent request.)					
Is the patient currently being treated with the drug requested? 🗌 Yes 🔲 No					
If yes, date started: Date of last dose received:		Number of doses received:			
Number of doses requested:					
E. Patient Clinical Information					
Primary Diagnosis Related to Medication Request:					
ICD Code(s):					
Gestational age: # weeks: # days:					
Birth weight: Current weight:	_ Date	current weight	recorded:		
Pertinent Concurrent Medications:					
Allergies:					

(continued on next page)

Clinical Conditions (2014 AAP Committee o	n Infectious Disease and Bronchiolitis Guidelines)
Chronic Lung Disease (CLD)	CLD of prematurity defined as gestational age ≤31 weeks, 6 days, AND requirement for 21% oxygen for at least the first 28 days after birth <12 months of age with CLD 12–24 months of age with CLD AND continues to require medical support during the 6-month period before second RSV season AND Supplemental oxygen (dates): Diuretic therapy (drugs/dates): Chronic corticosteroids (drugs/dates): Other Chronic Respiratory Disease arising in the perinatal period: Wilson-Mikity Syndrome (P27.0) Bronchopulmonary Dysplasia originating in the perinatal period (P27.1) Other chronic respiratory disease originating in the perinatal period (P27.8) Congenital Abnormality of the Lungs:
Congenital Heart Disease (CHD)	
Airway/Neuromuscular Conditions	 <12 months of age at start of season and compromised handling of secretions AND due to: Significant abnormality of the airway (attach clinical notes) Neuromuscular condition (attach clinical notes)
Prematurity	☐ ≤GA 28 weeks, 6 days AND <12 months at start of season
Other medical conditions or history	☐ Cystic Fibrosis ☐ Down's Syndrome ☐ Immunocompromised ☐ Describe other relevant medical history:
	dministered Medications (including Buy and Bill)
Start Date:	End Date:
Servicing Prescriber/Facility Name:	☐ Same as Prescribing Clinician
Servicing Provider/Facility Address:	
Servicing Provider NPI/Tax ID #:	
Name of Billing Provider:	
Billing Provider NPI #:	
Is this a request for reauthorization? Yes No CPT Code: # of Visits: J Code:	# of Units:
CPT Code: # of Visits: J Code:	# OI UTILS:

Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form.

Providers may attach any additional data relevant to medical necessity criteria.