SYNAGIS® PALIVIZUMAB

RESPIRATORY SYNCYTIAL VIRUS (RSV) PROPHYLAXIS:

Prior Authorization Form

Neighborhood Health Plan™

1 PATIENT INFORMATION

Last Name | First Name | Date of Birth

Sex: ☐ M ☐ F

Current Weight | Date recorded

Street Address

City | State | ZIP Code

Primary Guardian | Day Telephone (+ Area Code)

INSURANCE INFORMATION

Include copies of the patient's insurance cards and drug benefit cards (front and back) to expedite benefit clearance.

Primary Insurance | Secondary Insurance

Cardholder Name | Cardholder Name

Policy Number | Policy Number

2 PHYSICIAN INFORMATION

Prescriber's Name | Site Name | Office Contact

Address | City/State/ZIP Code

Prescriber's License Number | DEA Number | NPI Number

Telephone Number (+ Area Code) | Fax Number (+ Area Code)

Supervising Physician's Name (If Required for Mid-Level Practitioner) | License Number

3

FAX COMPLETED FORM TO:

Fax: (866) 249-6155

4 CLINICAL INFORMATION

Patients Gestational Age: _____ Weeks _____ Days

Does your patient have Chronic Lung Disease (CLD)? ☐ Yes ☐ No

If yes, did the patient require oxygen for at least 28 days after birth? ☐ Yes ☐ No

$\%O_2$ Required: _____ Dates Received (Start): _____ (End): _____

If your patient **is/will be older than 12 months on November 1st, please proceed:**

Check all that apply **and** provide most recent date provided:

☐ Supplemental O_2: _____ ☐ Diuretic: _____

☐ Systemic Corticosteroid: _____ ☐ Bronchodilator: _____

Does your patient have Congenital Heart Disease (CHD)? ☐ Yes ☐ No

Please note that children in their second year of life are not indicated for palvizumab (Synagis) prophylaxis per AAP Guidelines.

If your patient is **under 12 months** please proceed:

Is your patient **currently taking medication** to treat CHD? ☐ Yes ☐ No

If yes, please specify the medication: _____

Is your patient anticipating cardiac surgery? ☐ Yes ☐ No

Did/Will your patient receive a cardiac transplant during this RSV season? ☐ Yes ☐ No

Does your patient have anatomic pulmonary abnormalities or neuromuscular disorders that impair the ability to clear respiratory secretions from the upper airway? ☐ Yes (specify): _____ ☐ No

Is your patient profoundly immunocompromised? ☐ Yes (specify): _____ ☐ No

Does your patient have Cystic Fibrosis (CF)? ☐ Yes ☐ No

Is your patient nutritionally compromised? ☐ Yes (specify): _____ ☐ No

Is your patient's weight for length less than the 10th percentile? ☐ Yes (specify): _____ ☐ No

Did your patient require previous hospitalization for pulmonary exacerbation in the first year of life?

☐ Yes (specify): _____ ☐ No

Does your patient have abnormalities on chest radiography or chest computer tomography that persist when stable?

☐ Yes (specify): _____ ☐ No

Rationale for requesting Synagis: _____

Please submit all relevant and recent clinical notes for review.

Expected Date of First/Next Injection: _____ Injection already given? ☐ Yes, date(s): _____ ☐ No

*Please note that NHP covers Synagis from October 29th through March 15th for a maximum of **5 monthly doses.***

Deliver product to: ☐ Office ☐ Patient's Home ☐ Clinic Location: _____

Agency nurse to visit home for injection? ☐ Yes ☐ No ☐ Agency Name: _____

Rx

Synagis® (palivizumab) 50 mg and/or 100 mg vials

Sig: Inject 15 mg/kg IM one time per month (for liquid formulation only).

Dispense Quantity: QS Refill X: 1 2 3 4 months (please circle)

Known Allergies: _____

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's Signature _____ **Date** _____