



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Synagis

Phone: 215-991-4300 Fax back to: 866-240-3712

HEALTH PARTNERS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please print clearly.**

Patient Name:	Physician Name:
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Group Number:	NPI: State Lic. Id:
Address:	Address:
City, State, Zip:	City, State, Zip:

Drug Name: Expedited/Urgent

Directions:

Please answer the following questions and sign below:
Q1. Is the patient a neonate less than 28 weeks GA with or without CLD, and less than or equal to 12 months old at the start of the RSV season (October 15th through March 31st)? Yes No
Q2. Is the patient a neonate 29 to 32 weeks GA with or without CLD, and less than or equal to 6 months old at the start of the RSV season (October 15 through March 31st)? Yes No
Q3. Is the patient greater than 32 weeks, OR equal to or less than 35 weeks GA, with or without CLD, and less than 6 months old? Yes No
Q4. Does the patient have 2 or more of these risk factors -- A. Child Care Attendance; B. School-aged Siblings; C. Exposure to Environmental Air Pollutants; D. Congenital Abnormalities of the Airways; E. Severe Neuromuscular disease Yes No
Q5. Is the patient less than or equal to 24 months of age with congenital heart disease (CHD)? This includes infants receiving medication for CHF; infants with moderate-severe pulmonary HTN; infants with cyanotic heart disease. Yes No
Q6. Is the patient less than 24 months old with chronic lung disease (CLD) who required medical therapy (O2, bronchodilators, diuretics or corticosteroids) within 6 months of RSV season (October 15 through March 31)? Yes No

Physician Signature

Date

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