



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 note any information left blank or illegible may delay the review process.**

Patient Name:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic ID:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

Patient belongs to (please check one): HEALTH PARTNERS

KIDZPARTNERS

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign:

Q1. Weight: _____ lbs _____ oz = _____ kg Dose: 15mg/kg x _____ kg = _____ mg

Q2. Dose Requested:

50 mg

100 mg

Other dosage -- Must write in box below

Q3. Other Dosage: Please define the dosage

Q4. How many doses are requested?

1 2 3 4 5 6

Q5. Is the patient an infant less than or equal to 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

Q6. Is the patient less than or equal to 24 months of age with hemodynamically significant congenital heart disease (CHD)? This includes infants receiving medication to control congestive heart failure; infants with moderate-severe pulmonary hypertension; infants with cyanotic heart disease.

Yes No

Q7. Is the patient an infant 29 to 32 weeks GA (defined as greater than or equal to 31 weeks 6 days) 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

Q8. Is the patient greater than 32 weeks 0 days to 34 weeks 6 days GA, with or without CLD, and younger than 3 months



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Prescriber Name:

of age at start of RSV Season?

Yes No

Q9. Does the patient have any of these risk factors? Please check all that apply.

Infant attends child care

One or more siblings or other children younger than 5 years live permanently in the child's household

Q10. Is the patient less than or equal to 24 months old with chronic lung disease (CLD) who required medical therapy (supplemental oxygen, bronchodilators, diuretics or chronic corticosteroid therapy) within 6 months before the start of RSV season (October 15 through March 31)?

Yes No

Q11. Is the patient less than or equal to 12 months of age with significant congenital abnormalities of the airway or a neuromuscular condition that compromises handling of respiratory tract secretions?

Yes No

Q12. Has the patient received the first dose of palivizumab before discharge from the hospital?

Yes No

Q13. Comments:

Q14. Deliver to:

Physician's Office

Delivery Date

Q15. Delivery date needed:

Updated: 9-2010

Physician Signature

Date