Synagis (palivizumab) 2019-2020 Prior Authorization Form

Fax to: IEHP **Fax #: (909) 890-2058**

Patient Information

1st Scheduled Injection Date: _____ IEHP ID #: _____

Patient Name: _____ DOB: _____

Address: _____ City _____ Zip _____

Daytime Phone: _____ Evening Phone: _____ Best time to call: _____

Alternate Contact Name: _____ Telephone: _____

Prescribing Physician Information

Requesting Physician: _____ Specialty: _____

Administering Physician: _____ NPI #: _____

Administering Physician Office Address: _____

Phone #: _____ Fax #: _____

Shipping address (if different): _____

Responsible recipient for acceptance and storage of medication: _____

Statement of Medical Necessity

- ❑ Gestational Age less than 29 weeks (28 weeks, 6 days or less), less than 1 year of age (maximum of 5 doses)
- ❑ Chronic Respiratory Disease Prematurity of perinatal period, Bronchopulmonary Dysplasia, Interstitial Pulmonary fibrosis or Wilson-Mikity Syndrome (maximum of 5 doses)
- ❑ Other Respiratory Conditions arising in the newborn period
- ❑ Other (please indicate ICD10 code accurate diagnosis) _____

Additional Risk Factors:

- ❑ Treatment for Chronic Lung Disease during the second year of life within 6 months of the start of the RSV season who continue to require medical support (chronic corticosteroid therapy, diuretics or supplemental oxygen)
- ❑ Hemodynamically significant cyanotic or acyanotic Congenital Heart Disease, 12 months of age or younger (exclude ASD,VSD, pulmonic stenosis, PDA) (maximum of 5 doses)

Gestational Age at Birth (weeks): _____ Birth Weight (kg)_____

Current Age (months): _____ Current Weight (kg)_____

CCS Eligibility Status: _____

First Synagis Injection given: ____ /____ /____ Last Synagis Injection given: ____ /____ /____

Was there a hospital/NICU dose given? ☐ No ☐ Yes Date Given: ____ /____ /____

Prescription Information

☐ **Rx:** Synagis (palivizumab) **Sig:** Injection 15 mg/kg IM one time / month **Monthly Qty:** ____ 100 mg vial(s) ____ 50 mg vial(s) **Refill**s: _____ months

Physician Signature:	*Date:*

10801 6th St., Suite 120, Rancho Cucamonga, CA 91730
Tel (909) 890-2049 Fax (909) 890-2058
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