



**Independence
Blue Cross**

Prior Authorization Form

Synagis® (palivizumab)

Date: _____

Patient Name: _____ Patient DOB: _____

Patient Health Insurance ID #: _____ Office Contact: _____

Cardholder Name: _____ Day Phone: _____

Address: _____ Evening Phone: _____

City: _____ State: _____ Zip: _____

Prescribing Physician: _____ Office Phone #: _____

Provider NPI: _____ Office Fax #: _____

1. PRIMARY DIAGNOSIS:

Patient's Gestational Age: _____ Birth Weight: _____

Current Weight: _____ Date Recorded: _____

Chronic Respiratory Disease Arising in the Perinatal Period [CLD] (770.7) Congenital Heart Disease (747.0 – 745.4)

Congenital Abnormality of Respiratory System (748.3 – 748.4) Other

2. PATIENT HISTORY:

a. Does patient have bronchopulmonary dysplasia [BPD]? Yes No

b. Diagnosis of hemodynamically significant congenital heart disease? Yes No

c. Is patient receiving medical treatment? (check all that apply) Yes No

Oxygen, Date: _____ Corticosteroids, Date: _____

Bronchodilator, Date: _____ Diuretics, Date: _____

d. Has the following risk factors:

Day Care School Age Siblings Severe Neuromuscular Disease

Exposure to Environmental Pollutants (Includes Smoking Excludes Smoking)

Describe Pollutant: _____

Congenital anomaly of the airway

Other Medical History

e. Previous Injections? Yes No Expected date of 1st or next injection: _____

f. Does the patient have any allergies? No Yes: _____

Rx

Synagis® (palivizumab) 50 and/or 100mg vials and Sterile Water for injection 10mL

Sig: Reconstitute as directed and inject 15 mg/kg IM one time per month Dispense Quantity: QS

Refill _____ months Dispense as written Substitution Allow

Prescriber Signature: _____ Date: _____

FAX TO (215) 761-9165. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.

INTERNAL USE ONLY

Document #: _____ LOB: _____ M F Previous Auth Y N

APPROVED Reviewer Initials: _____ Date: _____