

Synagis Prior Authorization and Request Form 2009-2010 Season

Complete and fax to (800) 327-4561 For questions call (866) 554-2673

PATIENT DEMOGRAPHICS			
Patient Name: _____	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Insured Name: _____
Address: _____	Apt #: _____	Insurance Co: _____	
City: _____	State: _____	Zip Code: _____	Insurance ID: _____
Phone #: _____	Birth Date: _____	Group #: _____	SS#: _____

PRIMARY DIAGNOSIS											
Gestational Age: _____ Weeks _____ Days Chronological Age: _____ Weeks _____ Days Birth Weight: _____ kg <input type="checkbox"/> lbs <input type="checkbox"/>	Current Weight: _____ lbs _____ oz = _____ kg Date: _____ Dose: 15 mg / kg x _____ kg = _____ mg Months Synagis to be administered: Nov <input type="checkbox"/> Dec <input type="checkbox"/> Jan <input type="checkbox"/> Feb <input type="checkbox"/> Mar <input type="checkbox"/>										
<input type="checkbox"/> Congenital heart disease (747.0-747.9) <input type="checkbox"/> Chronic respiratory disease arising in the perinatal period (CLD) (770.7) <input type="checkbox"/> Other respiratory conditions of fetus/newborn (770..0-770.9) <input type="checkbox"/> Congenital anomalies of the respiratory system (748.0) <input type="checkbox"/> Other: _____ <input type="checkbox"/> Secondary Diagnosis: _____	<table style="width: 100%; border: none;"> <tr> <th colspan="2" style="text-align: center; border: none;">Gestational Age</th> </tr> <tr> <td style="border: none;"><input type="checkbox"/> < = 24 weeks GA (765.21-765.22)</td> <td style="border: none;"><input type="checkbox"/> 31-32 wks GA (765.26)</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> 25-26 wks GA (765.23)</td> <td style="border: none;"><input type="checkbox"/> 33-34 wks GA (765.27)</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> 27-28 wks GA (765.24)</td> <td style="border: none;"><input type="checkbox"/> 35-36 wks GA (765.28)</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> 29-30 wks GA (765.25)</td> <td style="border: none;"><input type="checkbox"/> 37 or > wks GA (765.29)</td> </tr> </table>	Gestational Age		<input type="checkbox"/> < = 24 weeks GA (765.21-765.22)	<input type="checkbox"/> 31-32 wks GA (765.26)	<input type="checkbox"/> 25-26 wks GA (765.23)	<input type="checkbox"/> 33-34 wks GA (765.27)	<input type="checkbox"/> 27-28 wks GA (765.24)	<input type="checkbox"/> 35-36 wks GA (765.28)	<input type="checkbox"/> 29-30 wks GA (765.25)	<input type="checkbox"/> 37 or > wks GA (765.29)
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MEDICAL CRITERIA (Please check appropriate boxes in ONE COLUMN ONLY and provide documentation as requested below)					
Gestational Age	<input type="checkbox"/> < 29 weeks	<input type="checkbox"/> 29 wks - < 32	<input type="checkbox"/> 32 wks - < 35 wks	<input type="checkbox"/> < 35 wks	All ages <input type="checkbox"/>
Chronological Age as of 10/15/09	<input type="checkbox"/> < 12 mo	<input type="checkbox"/> < 6 mo	<input type="checkbox"/> < 3 mo	<input type="checkbox"/> < 12 mo	< 24 mo <input type="checkbox"/>
	<input type="checkbox"/> 1 st RSV season		Must have 1 or more listed conditions: <input type="checkbox"/> Siblings <5yrs old <input type="checkbox"/> Attends day care	<input type="checkbox"/> Congenital airway abnormality <input type="checkbox"/> Severe neuromuscular disease <input type="checkbox"/> Other Specify: _____	<input type="checkbox"/> Hemodynamically significant congenital heart disease <input type="checkbox"/> Chronic lung disease treatment after 5/1/09 <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes provide medications) <input type="checkbox"/> Diuretic: _____ <input type="checkbox"/> Bronchodilator: _____ <input type="checkbox"/> Supplemental O2 Therapy <input type="checkbox"/> Other: _____
Required Documents	NICU Discharge Summary	NICU Discharge Summary	NICU Discharge Summary	NICU Discharge Summary	Clinical notes from the pediatrician/specialist including treatments for the last 6 months
	*5 DOSE MAX	*5 DOSE MAX	*3 DOSE MAX	*5 DOSE MAX	*5 DOSE MAX

PATIENT CURRENT MEDICATION PROFILE			
Medication	Strength	Dose	Any Known Allergies:
_____	_____	_____	_____

Deliver to: Physician Office Patient's Home

Rx
Synagis 50mg or Synagis 100mg Dispense Quantity: QS Sig: Inject 15mg/kg IM once/month Refill Monthly: _____ months
Physician Name (Print): _____ NPI #: _____ DEA #: _____
Ship to Address: _____ Suite/Apt: _____ Contact: _____
City: _____ State: _____ Zip: _____ Phone #: _____ Fax #: _____
Physician Signature: _____ Medically Necessary Date: _____

Form Effective Date 8/01/09

For more information, contact ICORE Healthcare:
 Hours 8:00 AM to 6:00 PM EST, Monday through Friday
 Fax (800) 327-4561 Phone (866) 554-2673



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