HIGHMARK
NORTHEASTERN NEW YORK

Outpatient Medical Injectable
Synagis Authorization Request Form
Fax to 833-619-5745 (Medical Benefit Only)

Member Name: _____DOB: _____

Member UMI: _____ ☐ Medicare ☐ Commercial

Address: _____

REQUESTING PHYSICIAN INFORMATION

Physician Name: _____ NPI: _____

Address: _____

Office Contact: _____ Phone Number: _____Fax Number: _____

MEDICAL INFORMATION

SYNAGIS (CPT 90378)

ICD10 Diagnosis Code(s): _____

Description(s): _____

_____

_____

Gestational Age: _____ Weeks _____Days

Birth Weight: _____kg *or* _____lbs _____oz

Current Age: _____ Weeks _____Days

Current Weight: _____kg *or* _____lbs_____oz

Date of current weight: _____

DOSING INFORMATION

Start Date:	
Number of doses infant has **already received** during current RSV season *(NICU and non-NICU doses)*	
Number of doses requested this current RSV season *(*Maximum of 5 doses within the local RSV season)*	

DISPENSING INFORMATION (please select one)

☐ Supplied by a Specialty Pharmacy *(for Home Infusion, Office – Professional, or Ambulatory Infusion Suite – Professional)*

Name: _____

NPI: _____

☐ Buy & Bill *(for Office – Professional or Outpatient Hospital administration)*

CLINICAL CRITERIA

****Please verify member's eligibility and benefits through the health plan****

Fax this completed form to Highmark at 1-833-619-5745

☐ **Current age < or = to 12 months**	☐ **Current age >12 months to <24 months**
(Check all that apply)	***(Check all that apply)***
☐ Infant with preterm birth less than 29 weeks 0 days gestation	☐ Infant is profoundly immunocompromised during the RSV season
☐ Infant with preterm birth less than 32 weeks 0 days with chronic lung disease (CLD) • Provide the maximum % oxygen required after birth: _____% • How many days after birth did the infant receive the above % oxygen: _____days	☐ Infant is undergoing a cardiac transplant
☐ Infant with hemodynamically significant congenital heart disease • Is the infant receiving medication to control congestive heart failure and will require cardiac surgical procedures? ☐ YES ☐ NO • Does the infant have moderate to severe pulmonary hypertension? ☐ YES ☐ NO • Does the infant have cyanotic heart disease? ☐ YES ☐ NO	☐ Infant with Cystic Fibrosis • Does the infant have symptoms of severe lung disease? ☐ YES ☐ NO *(ex: previous hospitalization for pulmonary exacerbation in the first year of life or an abnormal chest radiograph, computed tomography scan that persist when stable)* • Does the infant have a weight or length less than the 10th percentile? ☐ YES ☐ NO
☐ Infant born with congenital abnormalities of the airway	☐ Infant with a history chronic lung disease of prematurity that continues to require the following types of medical support • Chronic corticosteroids ☐ YES ☐ NO • Diuretic therapy ☐ YES ☐ NO • Supplemental Oxygen ☐ YES ☐ NO • Other: _____
☐ Infant born with a neuromuscular condition that compromises handling of respiratory secretions	
☐ Infant with Cystic Fibrosis with evidence of chronic lung disease (CLD) or nutritional compromise	
☐ Other: _____ _____	☐ Other: _____ _____ _____ _____

Please attach all pertinent clinical information **Attached:** ☐ **YES** ☐ **NO**	****Please send referral and prescription to dispensing pharmacy *(if applicable)***

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