



**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 **DISPENSING INFORMATION (please select one)**

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)*

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)*

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

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

CLINICAL CRITERIA

<input type="checkbox"/> Current age < or = to 12 months	<input type="checkbox"/> Current age >12 months to <24 months
<p><i>(Check all that apply)</i></p> <p><input type="checkbox"/> Infant with preterm birth less than 29 weeks 0 days gestation</p> <p><input type="checkbox"/> Infant with preterm birth less than 32 weeks 0 days with chronic lung disease (CLD)</p> <ul style="list-style-type: none"> • Provide the maximum % oxygen required after birth: _____% • How many days after birth did the infant receive the above % oxygen: _____days <p><input type="checkbox"/> Infant with hemodynamically significant congenital heart disease</p> <ul style="list-style-type: none"> • Is the infant receiving medication to control congestive heart failure and will require cardiac surgical procedures? <input type="checkbox"/> YES <input type="checkbox"/> NO • Does the infant have moderate to severe pulmonary hypertension? <input type="checkbox"/> YES <input type="checkbox"/> NO • Does the infant have cyanotic heart disease? <input type="checkbox"/> YES <input type="checkbox"/> NO <p><input type="checkbox"/> Infant born with congenital abnormalities of the airway</p> <p><input type="checkbox"/> Infant born with a neuromuscular condition that compromises handling of respiratory secretions</p> <p><input type="checkbox"/> Infant with Cystic Fibrosis with evidence of chronic lung disease (CLD) or nutritional compromise</p> <p><input type="checkbox"/> Other: _____</p> <p>_____</p>	<p><i>(Check all that apply)</i></p> <p><input type="checkbox"/> Infant is profoundly immunocompromised during the RSV season</p> <p><input type="checkbox"/> Infant is undergoing a cardiac transplant</p> <p><input type="checkbox"/> Infant with Cystic Fibrosis</p> <ul style="list-style-type: none"> • Does the infant have symptoms of severe lung disease? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(ex: previous hospitalization for pulmonary exacerbation in the first year of life or an abnormal chest radiograph, computed tomography scan that persist when stable)</i> • Does the infant have a weight or length less than the 10th percentile? <input type="checkbox"/> YES <input type="checkbox"/> NO <p><input type="checkbox"/> Infant with a history chronic lung disease of prematurity that continues to require the following types of medical support</p> <ul style="list-style-type: none"> • Chronic corticosteroids <input type="checkbox"/> YES <input type="checkbox"/> NO • Diuretic therapy <input type="checkbox"/> YES <input type="checkbox"/> NO • Supplemental Oxygen <input type="checkbox"/> YES <input type="checkbox"/> NO • Other: _____ <p><input type="checkbox"/> Other: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>

<p align="center">Please attach all pertinent clinical information</p> <p align="center">Attached: <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p align="center">**Please send referral and prescription to dispensing pharmacy (if applicable)</p>
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