



Drug Prior Authorization Synagis (palivizumab)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING

DATE:	PRESCRIBER FIRST & LAST NAME:
PATIENT FIRST & LAST NAME:	PRESCRIBER NPI:
PATIENT ADDRESS:	PRESCRIBER MAILING ADDRESS:
PATIENT ID:	PRESCRIBER PHONE:
PATIENT BIRTH DATE:	PRESCRIBER FAX:
PATIENT GENDER: MALE FEMALE	CONTACT PERSON:

Rx

Patient Name: _____
Patient DOB: _____ *Patient weight:* _____

Synagis 50mg/100mg vials
Sig: inject 15mg/kg IM every 28 days
Dispense: QS

Refill: during RSV season

Prescriber Signature: _____ **Date:** _____
NPI: _____ **Phone:** _____



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STEP 2: INFANT GA AND WEIGHT

INFANT GESTATIONAL AGE: _____ BIRTH WEIGHT: _____

CURRENT WEIGHT: _____ DATE RECORDED: _____

STEP 3: INFANT DIAGNOSIS (CHECK ONE)

DIAGNOSIS A: ≤ 28 WKS GESTATION **AND** ≤ 12 MONTHS OLD AT START OF RSV SEASON

REQUESTED DOSES: _____ (MAXIMUM OF 5)

DIAGNOSIS B: 29-32 WKS GESTATION **AND** ≤ 6 MONTHS OLD AT START OF RSV SEASON

REQUESTED DOSES: _____ (MAXIMUM OF 5)

DIAGNOSIS C: 33-35 WKS GESTATION **AND** ≤ 3 MONTHS OLD AT START OF RSV SEASON WHEN **ONE OF TWO** RISK FACTORS ARE PRESENT:

THE INFANT ATTENDS CHILD CARE

1 OR MORE CHILDREN YOUNGER THAN 5 YEARS LIVE PERMANENTLY IN THE SAME HOUSEHOLD

REQUESTED DOSES: _____ (MAXIMUM OF 3 OR PATIENT REACHES 3 MONTHS OLD)

DIAGNOSIS D: CHILD HAS CHRONIC LUNG DISEASE (CLD) **AND** IS ≤ 2 YEARS OLD AT START OF RSV SEASON **AND**

HAS **ONE OR MORE** OF THE FOLLOWING NEEDS WITHIN 6 MONTHS OF THE RSV SEASON OR WHO CONTINUE TO REQUIRE THERAPY:

SUPPLEMENTAL OXYGEN

REGULAR USE OF ORAL OR INHALER BRONCHODILATORS

CHRONIC CORTICOSTEROID THERAPY

REGULAR/INTERMITTENT USE OF DIURETICS FOR PULMONARY DISEASE

REQUESTED DOSES: _____ (MAXIMUM OF 5)

DIAGNOSIS E: CHILD HAS CONGESTIVE HEART DISEASE (CHD) **AND** IS ≤ 2 YEARS OLD AT START OF RSV SEASON **AND**

MEETS **ANY** OF THE FOLLOWING CRITERIA (CHOOSE AT LEAST ONE):

MEDICATIONS TO CONTROL CHF

MODERATE/SEVERE PULMONARY HYPERTENSION

CYANOTIC HEART DISEASE WITH NO/INCOMPLETE SURGICAL CORRECTION OF DEFECT

REQUESTED DOSES: _____ (MAXIMUM OF 5)

DIAGNOSIS F: CHILD HAS A CONGENITAL ABNORMALITY OR NEUROMUSCULAR CONDITION AFFECTING THE AIRWAYS **AND** IS ≤ 12 MONTHS OLD AT START OF RSV SEASON

REQUESTED DOSES: _____ (MAXIMUM OF 3 OR PATIENT REACHES 3 MONTHS OLD)

STEP 3: SYNAGIS ADMINISTRATION:

PROVIDER'S OFFICE PATIENT'S HOME: HOME HEALTH AGENCY REQUESTED: _____

REQUESTED DATE OF FIRST INJECTION: _____

STEP 3: SUBMISSION: COMPLETE AND FAX TO: US BIOSERVICES 1-866-706-0059

PRESCRIBER SIGNATURE:

Please contact Colorado Access Pharmacy Services at 303-751-9005 or 1-800-511-5010 from Monday-Friday 8am-6pm with any questions.