**MASSACHUSETTS STANDARD FORM FOR SYNAGIS® PRIOR AUTHORIZATION REQUESTS**

*Some plans might not accept this form for Medicare or Medicaid requests.*

### A. Destination

Health Plan or Prescription Plan Name: 

Health Plan Phone:  

Health Plan Fax:  

### B. Patient Information

Patient Name:  

DOB:  

Gender:  

Male  
Female  
Other:  

Member ID #:  

### C. Prescriber Information

Prescribing Clinician:  

Phone #:  

Specialty:  

Secure Fax #:  

NPI #:  

DEA #:  

Prescriber Point of Contact (POC) Name (if different than prescriber):  

POC Phone #:  

POC Secure Fax #:  

POC Email (not required):  

**Prescribing Clinician or Authorized Representative Signature:**  

**Date:**  

### D. Medication Information — SYNAGIS® (palivizumab)

**Check if Expedited Review/Urgent Request:**  

☐ (In checking this box, I attest to the fact that this request meets the definition and criteria for expedited review and is an urgent request.)

Is the patient currently being treated with the drug requested?  

☐ Yes  

☐ No  

If yes, date started:  

Date of last dose received:  

Number of doses received:  

Number of doses requested:  

### E. Patient Clinical Information

Primary Diagnosis Related to Medication Request:  

ICD Code(s):  

Gestational age:  

# weeks:  

# days:  

Birth weight:  

Current weight:  

Date current weight recorded:  

Pertinent Concurrent Medications:  

Allergies:  

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Massachusetts Collaborative — Massachusetts Standard Form for Synagis® Prior Authorization Requests  

January 2017 (version 1.0)
### Clinical Conditions (2014 AAP Committee on Infectious Disease and Bronchiolitis Guidelines)

#### Chronic Lung Disease (CLD)
- CLD of prematurity defined as gestational age ≤31 weeks, 6 days, AND requirement for 21% oxygen for at least the first 28 days after birth
- ☐ <12 months of age with CLD
- ☐ 12–24 months of age with CLD AND continues to require medical support during the 6-month period before second RSV season AND
  - Supplemental oxygen (dates): 
  - Diuretic therapy (drugs/dates): 
  - Chronic corticosteroids (drugs/dates): 
- Other 

#### Chronic Respiratory Disease arising in the perinatal period:
- ☐ Wilson-Mikity Syndrome (P27.0)
- ☐ Bronchopulmonary Dysplasia originating in the perinatal period (P27.1)
- ☐ Other chronic respiratory disease originating in the perinatal period (P27.8)

#### Congenital Abnormality of the Lungs:

#### Congenital Heart Disease (CHD)
- ☐ <12 months of age at start of season with hemodynamically significant CHD such as:
  - Acyanotic heart disease and receiving medication to control congestive heart failure and surgery to correct
    - (drugs/dates): 
    - (surgery date): 
  - Moderate to severe pulmonary hypertension
  - Other (describe): 
  - ☐ 12–24 months of age undergoing cardiac transplant during RSV season (date of planned surgery): 
  - Cyanotic Heart Disease — Diagnosis:

#### Airway/Neuromuscular Conditions
- ☐ <12 months of age at start of season and compromised handling of secretions AND due to:
  - ☐ Significant abnormality of the airway (attach clinical notes)
  - ☐ Neuromuscular condition (attach clinical notes)

#### Prematurity
- ☐ ≤ GA 28 weeks, 6 days AND <12 months at start of season

### Other medical conditions or history
- ☐ Cystic Fibrosis
- ☐ Down's Syndrome
- ☐ Immunocompromised
- Describe other relevant medical history:

### Complete this section for Professionally Administered Medications (Including Buy and Bill)

<table>
<thead>
<tr>
<th>Start Date:</th>
<th>End Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Servicing Prescriber/Facility Name:</td>
<td>☐ Same as Prescribing Clinician</td>
</tr>
<tr>
<td>Servicing Provider/Facility Address:</td>
<td></td>
</tr>
<tr>
<td>Servicing Provider NPI/Tax ID #:</td>
<td></td>
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<tr>
<td>Name of Billing Provider:</td>
<td></td>
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<tr>
<td>Billing Provider NPI #:</td>
<td></td>
</tr>
<tr>
<td>Is this a request for reauthorization? ☐ Yes ☐ No</td>
<td></td>
</tr>
<tr>
<td>CPT Code:</td>
<td># of Visits:</td>
</tr>
</tbody>
</table>

*Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form.*

*Providers may attach any additional data relevant to medical necessity criteria.*