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:
### 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:**
- ☐ 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 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):

**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:

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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?</td>
<td>☐ Yes ☐ No</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.*