



# MASSACHUSETTS STANDARD FORM FOR SYNAGIS® PRIOR AUTHORIZATION REQUESTS

Version 1.0      Effective: 01/01/2021

Phone: 800-753-2851      Fax back to: 1-833-951-1680

*\*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 Name (POC) (if different than prescriber):

POC Phone #:

POC Secure Fax #:

POC Email (not required):

**Prescribing Clinician or Authorized Representative Signature:**

**Date:**

## D. Medication Information

**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)	
<b>Chronic lung Disease (CID)</b>	<p>CLD of prematurity defined as gestational age <math>\leq</math> 31 weeks, 6 days, AND requirement for 21% oxygen for at least the first 28 days after birth</p> <p><input type="checkbox"/> &lt;12 months of age with CLD</p> <p><input type="checkbox"/> 12-24 months of age with CLD AND continues to require medical support during the 6-month period before second RSV season AND</p> <p style="margin-left: 20px;"><input type="checkbox"/> Supplemental oxygen (dates): _____</p> <p style="margin-left: 20px;"><input type="checkbox"/> Diuretic therapy (drugs/dates): _____</p> <p style="margin-left: 20px;"><input type="checkbox"/> Chronic corticosteroids (drugs/dates): _____</p> <p><input type="checkbox"/> Other _____</p> <p><b>Chronic Respiratory Disease arising in the perinatal period:</b></p> <p><input type="checkbox"/> Wilson-Mikity Syndrome (P27.0)</p> <p><input type="checkbox"/> Bronchopulmonary Dysplasia originating in the perinatal period (P27.1)</p> <p><input type="checkbox"/> Other chronic respiratory disease originating in the perinatal period (P27.8)</p> <p><b>Congenital Abnormality of the Lungs:</b> _____</p> <p>_____</p> <p>_____</p>
<b>Congenital Heart Disease (CHD)</b>	<p><input type="checkbox"/> &lt;12 months of age at start of season with hemodynamically significant CHD such as:</p> <p style="margin-left: 20px;">Acyanotic heart disease and receiving medication to control congestive heart failure and surgery to correct _____</p> <p style="margin-left: 20px;">(drugs/dates): _____</p> <p style="margin-left: 20px;">(surgery date): _____</p> <p style="margin-left: 20px;">Moderate to severe pulmonary hypertension</p> <p style="margin-left: 20px;">Other (describe): _____</p> <p style="margin-left: 20px;">12-24 months of age undergoing cardiac transplant during RSV season (date of planned surgery): _____</p> <p style="margin-left: 20px;">Cyanotic Heart Disease— Diagnosis: _____</p>
<b>Airway/Neuromuscular Conditions</b>	<p><input type="checkbox"/> &lt;12 months of age at start of season and compromised handling of secretions AND due to:</p> <p style="margin-left: 20px;">Significant abnormality of the airway (attach clinical notes)</p> <p style="margin-left: 20px;">Neuromuscular condition (attach clinical notes)</p>
<b>Prematurity</b>	<input type="checkbox"/> $\leq$ GA 28 weeks, 6 days AND <12 months at start of season
<b>Other medical conditions or history</b>	<p><input type="checkbox"/> Cystic Fibrosis    <input type="checkbox"/> Down's Syndrome    <input type="checkbox"/> Immunocompromised</p> <p><input type="checkbox"/> Describe other relevant medical history: _____</p> <p>_____</p> <p>_____</p>
Complete this section for Professionally Administered Medications {including Buy and Bill}	
Start Date:	End Date:
Servicing Prescriber/Facility Name:	<input type="checkbox"/> Same as Prescribing Clinician
Servicing Prescriber/Facility Address:	
Servicing Provider NPI/TAX ID#:	
Name of billing provider:	
Billing Provider NPI#	
Is this a request for reauthorization? <input type="checkbox"/> Yes <input type="checkbox"/> No	
CPT Code: _____	# of Visits: _____ J Code: _____ # of Units: _____

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.

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