



**BlueCross BlueShield
of Illinois**

PRIOR AUTHORIZATION: Synagis® (palivizumab)

PATIENT NEEDS SYNAGIS ON/OR BEFORE THIS DATE: _____

Delivery location: MD office Patient home Clinic

Coordinate nursing: Yes No

Agency: _____ Phone: _____

Patient Information			Physician Information		
Patient last name:	Patient first name:	Middle init:	Practice name:	Prescriber's name:	
Street address:			Prescriber's State License #:	DEA #:	NPI #:
City:	State:	Zip:	Synagis Contact Name:	Phone #:	Fax #:
DOB:	Phone Number:	GA:	Address:		City:
Birth weight (kg/lb):		Current weight (kg/lb):	State:		Zip:
Blue Cross Identification #:		Blue Cross Group #:	Code for Synagis: 90378		
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female					

FIRST Season RSV Prophylaxis Prior Authorization Synagis® (palivizumab)

<input type="checkbox"/> 28 weeks 6 Days Max of 5 doses DOB 10-1-2008 or later	<input type="checkbox"/> 29 Wks 0 Days to 31 wks 6 Days Max of 5 doses DOB 4-1-2009 or later
<input type="checkbox"/> 32 wks, 0 days to 34 wks, 6 days Max. of 3 doses and DOB 7/1/2009 or later	<p>The following risk factors are for data collection only, are not part of the American Academy of Pediatrics Guidelines for RSV prophylaxis, and are not used for coverage.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Low birth weight (<2500 g) <input type="checkbox"/> Crowded living conditions <input type="checkbox"/> Multiple birth <input type="checkbox"/> Family history of asthma <input type="checkbox"/> Other
<ul style="list-style-type: none"> <input type="checkbox"/> At least one sibling 5 years of age or less <input type="checkbox"/> Daycare attendance <p>Only 1 of the above 2 factors must be met.</p>	
<input type="checkbox"/> Chronic lung disease (CLD) Maximum of 5 doses DOB 10/1/2008 or later and medical therapy for CLD <ul style="list-style-type: none"> <input type="checkbox"/> Supplemental O2 therapy, <input type="checkbox"/> Bronchodilators, <input type="checkbox"/> Diuretics, and/or <input type="checkbox"/> Corticosteroids, after 4/1/2008 	<input type="checkbox"/> Congenital heart disease (CHD) Maximum of 5 doses DOB 10/1/2008 or later <u>and</u> hemodynamically significant heart disease including but not limited to: <ul style="list-style-type: none"> <input type="checkbox"/> Moderate to severe pulmonary hypertension, or <input type="checkbox"/> Congestive heart failure, or <input type="checkbox"/> Cyanotic heart disease/hypoxia, or <input type="checkbox"/> Anticipated surgery during the RSV season requiring cardiopulmonary bypass

SECOND Season RSV Prophylaxis Prior Authorization Synagis® (palivizumab)

<input type="checkbox"/> Chronic lung disease (CLD) Maximum of 5 doses DOB 10/1/2007 or later and medical therapy for CLD <ul style="list-style-type: none"> <input type="checkbox"/> Supplemental O2 therapy, <input type="checkbox"/> Bronchodilators, <input type="checkbox"/> Diuretics, and/or <input type="checkbox"/> Corticosteroids, after 4/1/2008. 	<input type="checkbox"/> Congenital heart disease (CHD) Maximum of 5 doses DOB 10/1/2007 or later <u>and</u> hemodynamically significant heart disease including but not limited to: <ul style="list-style-type: none"> <input type="checkbox"/> Moderate to severe pulmonary hypertension, or <input type="checkbox"/> Congestive heart failure, or <input type="checkbox"/> Cyanotic heart disease/hypoxia, or <input type="checkbox"/> Anticipated surgery during the RSV season requiring cardiopulmonary bypass
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Prescription Information

Synagis® (palivizumab) kit 50mg and/or 100mg vials, needles & syringes. Sig: Inj 15 mg/kg IM every 28 days

Physician Signature: _____ Date: _____

Fax this completed form to RSV Connection™ at 1-866-252-1749

Triessent Team:

Phone: 1-888-216-6710

Fax 1-866-203-6010

TTY : 1-866-230-7268

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