



INLAND EMPIRE HEALTH PLAN

Synagis (palivizumab) Prior Authorization Form

Fax to: IEHP

Fax #: (909) 890-2058

Patient Information

1st Scheduled Injection Date: _____ IEHP ID #: _____
 Patient Name: _____ DOB: _____
 Address: _____ City _____ Zip _____
 Daytime Phone: _____ Evening Phone: _____ Best time to call: _____
 Alternated Contact Name: _____ Telephone: _____

Prescribing Physician Information

Physician Name: _____ Specialty: _____
 Practice Name & Address: _____
 Phone #: _____ Fax #: _____
 Tax ID #: _____ IEHP Provider #: _____
 Shipping address (if different): _____

Statement of Medical Necessity

- 765.0 Gestational Age less than or equal to 28 weeks, less than 1 year of age (maximum of 5 doses)
- 765.1 Gestational age 29 – 32 weeks (31 wks, 6 days), less than 6 months of age (maximum of 5 doses)
- 765.1 Gestational age 32 (31 wks, 6 days) – 35 weeks (34 wks, 6 days), with risk factors and younger than 3 months of age at the start of the RSV season
- 770.7 Chronic Respiratory Disease Prematurity of perinatal period, Bronchopulmonary Dysplasia, Interstitial Pulmonary fibrosis or Wilson-Mikity Syndrome (maximum of 5 doses)
- 770.0 – 770.9 Other Respiratory Conditions arising in the newborn period
- Other (please indicate ICD9 CM Code accurate diagnosis) _____

Additional Risk Factors:

- Treatment for Chronic Lung Disease within 6 months of the RSV season, less than 24 months of age (treatment with chronic corticosteroid therapy, diuretics, or bronchodilators)
- Hemodynamically significant cyanotic or acyanotic Congenital Heart Disease, less than 24 months of age (exclude ASD, VSD, pulmonic stenosis, PDA) (maximum of 5 doses)

Gestational Age at Birth (weeks): _____ Birth Weight (kg) _____

CCS Eligibility Status: _____

Prescription Information

<input type="checkbox"/> Synagis (palivizumab) Sig: <input type="checkbox"/> Injection 15 mg/kg IM one time / month Monthly Qty: _____ 100 mg vial(s) _____ 50 mg vial(s) Refill _____ months	Other: _____	Current Weight: _____
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Physician Signature: _____ *Date:* _____

Your request is: **Approved** **Request for More Information** **Denied**
Valid from: **Expires on:** **Decision by:** **Date:**

Comments: _____