

SYNAGIS AUTHORIZATION REQUEST (Palivizumab)



Name: _____
Member ID #: _____
Phone #: _____
DOB: _____
PCP: _____

Date of Request _____

Instructions:

- 1) Complete information on form.
- 2) Please note, if patient is CCS eligible, a delay in processing your request may occur as we check for CCS eligibility.
- 3) Providers: FAX form to CCHP: (925) 313-6412 CCHP Pharmacy Unit Help Desk: (925) 957-7260 (option 2)
- 4) Approved or Denied authorizations will be communicated to the requesting physician &/or clinic contact person.

Patient Name _____ MRN _____ Clinic site _____

Date of Birth _____ Birth Weight _____ Requesting Physician _____
(state Kg or lb, oz) (print)

1. Gestational Age at Birth in weeks _____
2. Age at the start of RSV season (November 1) _____
3. If the gestational age at birth was between 32 weeks, 0 days and 34 weeks, 6 days and the infant is <3 months on Nov.1, does the infant have any one of the following risk factors? Please note a maximum of 3 doses will be authorized for this age group thru 3 months of age.

_____ Child care attendance
_____ Siblings younger than 5 years of age

4. Is this patient is less than 2 years old, do they continue to require medical therapy for:

_____ Chronic lung disease (does not include asthma)
_____ Congenital heart disease

(Please send documentation re: above conditions)

5. Infants current weight in kg: _____ as of (date): _____

6. Date of most recent Synagis dose if received prior to hospital discharge: _____

7. Provider's Signature _____ Date _____

7. Clinic contact person _____ PHONE# _____ FAX# _____
print

(For CCRMC: Authorization approval / denial or deferment with comments will be found in MediTech #2 MOX, Library under #71 Authorizations)