Synagis (palivizumab) 2019-2020 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: _______________
Alternate Contact Name: __________________ Telephone: ____________________

Prescribing Physician Information

Requesting Physician: _____________________________ Specialty: ____________________
Administering Physician: ___________________________ NPI #: ____________________
Administering Physician Office Address: ___________________________________________
Phone #: __________________________ Fax #: __________________________

Shipping address (if different): ___________________________________________

Responsible recipient for acceptance and storage of medication: _______________________

Statement of Medical Necessity

❑ Gestational Age less than 29 weeks (28 weeks, 6 days or less), less than 1 year of age (maximum of 5 doses)
❑ Chronic Respiratory Disease Prematurity of perinatal period, Bronchopulmonary Dysplasia, Interstitial Pulmonary
  fibrosis or Wilson-Mikity Syndrome (maximum of 5 doses)
❑ Other Respiratory Conditions arising in the newborn period
❑ Other (please indicate ICD10 code accurate diagnosis) ___________________________________________

Additional Risk Factors:
❑ Treatment for Chronic Lung Disease during the second year of life within 6 months of the start of the RSV season who
  continue to require medical support (chronic corticosteroid therapy, diuretics or supplemental oxygen)
❑ Hemodynamically significant cyanotic or acyanotic Congenital Heart Disease, 12 months of age or younger (exclude
  ASD, VSD, pulmonic stenosis, PDA) (maximum of 5 doses)

Gestational Age at Birth (weeks): ____________________ Birth Weight (kg) __________________
Current Age (months): ____________________ Current Weight (kg) __________________

CCS Eligibility Status: __________________________________________________________________

First Synagis Injection given: ____ / ____ / ____ Last Synagis Injection given: ____ / ____ / ____

Was there a hospital/NICU dose given? □ No □ Yes Date Given: ____ / ____ / ____

Prescription Information

❑ Rx: Synagis (palivizumab) Sig: Injection 15 mg/kg IM one time / month Monthly Qty: ____ 100 mg vial(s) ____ 50 mg vial(s) Refills: _______ months

Physician Signature: ___________________________ Date: __________________

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Visit our web site at: www.iehp.org
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