



**Outpatient Medical Injectable
Synagis Authorization Request Form
Fax to 833-581-1861 (Medical Benefit Only)**

Member Name: _____ DOB: _____

Member ID (UMI): _____ Medicare Commercial*

Address: _____

ORDERING/ATTENDING PROVIDER

Provider Name: _____ NPI: _____

Address: _____

Office Contact: _____ Phone Number: _____ Fax Number: _____

SERVICING FACILITY/VENDOR

Facility Name: _____ NPI: _____

Address: _____

Phone Number: _____ Fax Number: _____

MEDICAL INFORMATION

ICD10 Diagnosis Code(s): _____ Description(s): _____ _____	Gestational Age: _____ Weeks _____ Days Birth Weight: _____ kg or _____ lbs _____ oz Current Age: _____ Weeks _____ Days Current Weight: _____ kg or _____ lbs _____ oz Date of current weight: _____
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DOSING INFORMATION

Requested Start Date:		
Number of doses infant has already received during current RSV season (<i>NICU and non-NICU doses</i>)		
Number of doses requested this current RSV season (<i>*Maximum of 5 doses within the local RSV season</i>)		

DRUG SUPPLIER

***For providers in Western PA and West Virginia, the specialty pharmacy will be assigned by Free Market Health. All other providers please specify below:**

Supplied by a Specialty Pharmacy (*For Home Infusion, Office – Professional, or Ambulatory Infusion Suite – Professional*)

Pharmacy Name: _____

Pharmacy NPI: _____

Buy & Bill (*For Office – Professional or Outpatient Hospital administration*)

****Please verify member's eligibility and benefits through the health plan****

CLINICAL CRITERIA	
<input type="checkbox"/> Current age < or = to 12 months	<input type="checkbox"/> Current age >12 months to <24 months
<p><u>(Check all that apply)</u></p> <p><input type="checkbox"/> Infant with preterm birth less than 29 weeks 0 days gestation</p> <p><input type="checkbox"/> Infant with preterm birth less than 32 weeks 0 days with chronic lung disease (CLD)</p> <ul style="list-style-type: none"> • Provide the maximum % oxygen required after birth: _____% • How many days after birth did the infant receive the above % oxygen: _____days <p><input type="checkbox"/> Infant with hemodynamically significant congenital heart disease</p> <ul style="list-style-type: none"> • Is the infant receiving medication to control congestive heart failure and will require cardiac surgical procedures? <input type="checkbox"/> YES <input type="checkbox"/> NO • Does the infant have moderate to severe pulmonary hypertension? <input type="checkbox"/> YES <input type="checkbox"/> NO • Does the infant have cyanotic heart disease? <input type="checkbox"/> YES <input type="checkbox"/> NO <p><input type="checkbox"/> Infant born with congenital abnormalities of the airway</p> <p><input type="checkbox"/> Infant born with a neuromuscular condition that compromises handling of respiratory secretions</p> <p><input type="checkbox"/> Infant with Cystic Fibrosis with evidence of chronic lung disease (CLD) or nutritional compromise</p> <p><input type="checkbox"/> Other: _____</p> <p>_____</p>	<p><u>(Check all that apply)</u></p> <p><input type="checkbox"/> Infant is profoundly immunocompromised during the RSV season</p> <p><input type="checkbox"/> Infant is undergoing a cardiac transplant</p> <p><input type="checkbox"/> Infant with Cystic Fibrosis</p> <ul style="list-style-type: none"> • Does the infant have symptoms of severe lung disease? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(ex: previous hospitalization for pulmonary exacerbation in the first year of life or an abnormal chest radiograph, computed tomography scan that persist when stable)</i> • Does the infant have a weight or length less than the 10th percentile? <input type="checkbox"/> YES <input type="checkbox"/> NO <p><input type="checkbox"/> Infant with a history chronic lung disease of prematurity that continues to require the following types of medical support</p> <ul style="list-style-type: none"> • Chronic corticosteroids <input type="checkbox"/> YES <input type="checkbox"/> NO • Diuretic therapy <input type="checkbox"/> YES <input type="checkbox"/> NO • Supplemental Oxygen <input type="checkbox"/> YES <input type="checkbox"/> NO • Other: _____ <p><input type="checkbox"/> Other: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>

<p>Please attach all pertinent clinical information</p> <p>Attached: <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
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