HIGHMARK.

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: _____

DOSING INFORMATION

Requested Start Date:

Number of doses infant has **already received** during current RSV season *(NICU and non-NICU doses)*	
Number of doses requested this current RSV season *(*Maximum of 5 doses within the local RSV season)*	

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	
☐ **Current age < or = to 12 months**	☐ **Current age >12 months to <24 months**
(Check all that apply)	***(Check all that apply)***
☐ Infant with preterm birth less than 29 weeks 0 days gestation ☐ Infant with preterm birth less than 32 weeks 0 days with chronic lung disease (CLD) • Provide the maximum % oxygen required after birth: _____% • How many days after birth did the infant receive the above % oxygen: _____days ☐ Infant with hemodynamically significant congenital heart disease • Is the infant receiving medication to control congestive heart failure and will require cardiac surgical procedures? ☐ YES ☐ NO • Does the infant have moderate to severe pulmonary hypertension? ☐ YES ☐ NO • Does the infant have cyanotic heart disease? ☐ YES ☐ NO ☐ Infant born with congenital abnormalities of the airway ☐ Infant born with a neuromuscular condition that compromises handling of respiratory secretions ☐ Infant with Cystic Fibrosis with evidence of chronic lung disease (CLD) or nutritional compromise ☐ Other: _____ _____	☐ Infant is profoundly immunocompromised during the RSV season ☐ Infant is undergoing a cardiac transplant ☐ Infant with Cystic Fibrosis • Does the infant have symptoms of severe lung disease? ☐ YES ☐ NO *(ex: previous hospitalization for pulmonary exacerbation in the first year of life or an abnormal chest radiograph, computed tomography scan that persist when stable)* • Does the infant have a weight or length less than the 10th percentile? ☐ YES ☐ NO ☐ Infant with a history chronic lung disease of prematurity that continues to require the following types of medical support • Chronic corticosteroids ☐ YES ☐ NO • Diuretic therapy ☐ YES ☐ NO • Supplemental Oxygen ☐ YES ☐ NO • Other: _____ ☐ Other: _____ _____ _____ _____

Please attach all pertinent clinical information

Attached: ☐ **YES** ☐ **NO**