SYNAGIS® *(PALIVIZUMAB)* PRIOR AUTHORIZATION FORM
COMPLETE AND FAX TO ELIXIR AT 1-866-422-9119

PATIENT INFORMATION

First Name:			Last Name:
Street Address:			City:
State:	Zip:	Phone:	Date of Birth:
Plan:	TOTAL HEALTH CARE		
Member ID:		☐ Male	☐ Female

CLINICAL INFORMATION

☐765.21 – 765.29 Gestational Age (please select below)

☐ ≤ 24 weeks ☐ 25–26 weeks ☐ 27-28 weeks ☐ 29-30 weeks ☐ 31-32 weeks ☐ 33-34 weeks ☐ 35-36 weeks ☐ 37 weeks

Actual Gestational Age: ______________ Age as of 11/1: ☐ <6 months ☐ <12 months ☐ <24 months

Birth Weight: ______________ Current Weight: ______________ Date Recorded: ______________

☐ First Season Administration ☐ Second Season Administration

☐770.7 Chronic Lung Disease

Is the patient ≤ 24 months of age and receiving medical treatment ☐ Yes (check all that apply with in last 6 months) ☐ No

☐ Oxygen ☐ Corticosteroids ☐ Bronchodilators ☐ Diuretics

☐747.0 – 747.9 Congenital Heart Disease (Hemodynamically Significant) Specify Rxs:

Is the patient ≤ 24 months of age ☐ Yes(check all that apply) ☐ No

☐ CHF ☐ Moderate to Severe Pulmonary Hypertension ☐ CHD (Cyanotic Heart Disease)

Check the following Risk Factors that apply:

☐ School age siblings ☐ Daycare attendance ☐ Exposure to environmental air pollutants

☐ Severe neuromuscular disease ☐ Congenital abnormality of airway ☐ Multiple birth

☐ Birth weight < 2500 grams ☐ Other

Did the patient spend time in the NICU ☐ Yes (provide NICU dose given ______________________________) ☐ No

Note: ***PLEASE PROVIDE CHART NOTES TO DOCUMENT AND SUPPORT STATEMENTS MADE ABOVE***
Upon approval determination this information will be supplied to our preferred specialty vendor whom will contact you for the prescription and delivery information.

Additional Information:

PHYSICIAN INFORMATION

Name of person completing this form:			Date faxed:
Physician Name:			NPI or DEA #:
Address:			Practice Name:
City:		State:	Zip:
Phone Number:			Fax Number:
Action Needed	☐ Urgent	☐ For Review	Pharmacy Fax:

DRUG/CLINICAL INFORMATION

☐ Initial request ☐ Renewal Drug requested: ______________________ Proposed duration of therapy: ____________

Strength/Quantity: __________________________ Daily dose: _________________ Height: ___________ Weight: __________

Sig. ____

☐ Supplies package (no charge): sharps disposal unit (regular or large), alcohol wipes (100 per box), syringes as necessary

Prescriber's Signature ____ Date ____________________

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