Premier Health Plan
Pharmacy Services
Commercial Phone: 855-266-0713
Exchange Phone: 866-822-2413
Fax: 855-862-6518

SYNAGIS
Prior Authorization Form

□ Standard Request □ Expedited Request	If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. ***For state exchanges only:*** The above disclaimer applies for exigent circumstances. Expedited review may also be requested when you are undergoing a current course of treatment using a non-formulary drug.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested:	Strength:	Directions:	Quantity Dispensed:	Day Supply:
Synagis (Palivizumab)	□ 50mg Powder (IV) □ 50mg/0.5ml Solution □ 100mg Powder (IV) □ 100mg/ml Solution			
□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.		

Billing Information

□ Billed by **PHARMACY** dispensed to the member *or* provider for administration.	□ Billed under **MEDICAL** benefit by provider. J CODE:_____ ICD-10 Code:_____	Place of Administration: □ Physician's Office □ Hospital/Clinic □ Patient Home

Clinical Information

Patient Gestational Age (GA):	Birth Weight (provide units):	Current Weight (provide units):	Date Recorded:

Does the patient have Chronic Lung Disease? □ Yes □ No
If yes, please specify the diagnosis:_____
Therapies used within the past 6 months for the above diagnosis (check all that apply):

□ Supplemental oxygen □ Bronchodilator(s) □ Diuretics □ Corticosteroids

Please list all medications the patient currently is using or has used in the past for the above diagnosis

Medication Name	Strength/ Frequency	Dates of Therapy	Reason for Discontinuation

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Member Name:	DOB:	Health Plan ID:
Please be sure to complete and include this page with the 1st page of this form.		

Does the patient have hemodynamically significant Congenital Heart Disease? ☐ Yes ☐ No

If yes, please specify the diagnosis:

☐ Congestive Heart Failure (CHF) ☐ Cyanotic disease ☐ Severe Pulmonary Hypertension ☐ Other:_____

Does the patient have either of the following risk factors?

☐ Daycare attendance ☐ Sibling younger than 5 years old Age:_____

Was a NICU dose given? ☐ No ☐ Yes (specify date):_____

Please provide any additional information which should be considered in the space below: