New Mexico Synagis Prior Authorization/Statement of Medical Necessity/Order Form

NDC code: 50 mg vial: 60574-4114-01 ***100 mg vial: 60574-4113-01*** **Valid 2019-2020**

BCBS	**Presbyterian**	Western Sky	Molina	Other	**Today's Date:**

Patient Name:	**Gender:**	**DOB:**	**Child's Wt. (current Kg)**
Patient SS#/Insurance ID:		Parent/Guardian Name:	
Patient Address:			
Patient Primary Phone:		Phone 2:	
Primary Insurance:		Insurance 2:	
Practitioner's Name:		Office Contact Name:	
Practitioner's Address:			
Practitioner's Phone:		Practitioner's Fax:	

NICU Graduate: Yes_____No_____Unknown_____	Date of first dose:	Location first dose:	Received last year? Yes___No _____

Gestational Age: _____ **less than or equal to 28 weeks, 6 days OR other criteria met

ICD Code: | P07.30 Premature _____Other:

Circle the one criterion that best applies to this patient (one of the following must be circled and supporting documentation must be supplied):		**ICD 10 Code:**
1	<12 months old (as of November 15) and with **hemodynamically significant congenital heart disease (CHD)**	
2 (a)	a. <12 months old (as of November 15), < 32 wks 0 days with **chronic lung disease (CLD) of prematurity** requiring oxygen of FiO2 >21% for >28 days after birth	
2 (b)	b. <24 months with **chronic lung disease (CLD) and continues** on supplemental oxygen, diuretic or corticosteroid	
3	<24 months old (as of November 15) and with **Severe Immunodeficiency** (specify type)	
4	<12 months old (as of November 15) with **Severe Neuromuscular Disease with inability to clear secretions**	
5	<12 months old (as of November 15) with **congenital abnormality of the airway** with inability to clear secretions	
6	<12 months old (as of November 15) and born at **28 wks, 6 days gestation** or less	
7	<24 months old (as of Nov. 15) and will undergo cardiac transplantation during the RSV season	

STATEMENT OF MEDICAL NECESSITY

I hereby certify that the above services are medically necessary and are authorized by me. This patient is under my care and is in need of the services listed.

INDIVIDUAL ORDERS (check one):

- ☐ Administer Synagis (Palivizumab) 15 mg/kg IM monthly (q28-31 days) for duration of RSV season as determined by patient's health insurance plan. Epinephrine 1:10,000; 0.01 mg/kg for anaphylaxis as directed.
- ☐ Arrange home health care agency to administer Synagis (Palivizumab).
- ☐ Deliver to practitioner office if no home health agency available.

Practitioner Signature : **X**	**Parent Signature:** **X**	**Date:**

APPROVED: Authorization #	**Authorization by:**
DENIED:	

Presbyterian
<Fax: (505) 923-5540 or 800-724-6953>
Centennial & Commercial Coordinator:<Antoinette Vigil,(505) 923-2065>

For help with patient financial assistance, PAs, additional assistance with care coordination or other issues, consider SOBI Synagis CONNECT at 1-866-285-8419 or https://synagisconnect.com/

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