



FAX COMPLETED FORM TO 401-435-3319

1 SYNAGIS® PRIOR AUTHORIZATION - PATIENT INFORMATION

Form fields for patient information: Last Name, First Name, Middle Initial, Street Address, City, State, Zip Code, Day Telephone, Evening Telephone, Date of Birth, Social Security Number, Sex, Parent/Guardian.

INSURANCE INFORMATION

Include copies of the patient's insurance cards and drug benefit cards (front and back) to expedite benefit clearance.

Form fields for insurance information: Primary Insurance, Secondary Insurance, Cardholder Name & Social Security Number, ID Number, Authorization Number/Units, Authorized by, Patient Responsibility, Verified by, Date/Time.

2 PHYSICIAN INFORMATION

Form fields for physician information: Prescriber's Name, Hospital/Clinic, Office Contact, Address, City/State/Zip, Telephone Number, Prescriber's Group Name, Fax Number, Prescriber's License Number, DEA Number, NPI Number.

3 RESPIRATORY SYNCYTIAL VIRUS (RSV) PROPHYLAXIS STATEMENT OF MEDICAL NECESSITY - CLINICAL INFORMATION

Form fields for clinical information: Gestational Age (weeks), Birth Weight (kg/lbs), Most Recent Weight (kg/lbs), Date Recorded.

ONE OF THE FOLLOWING CRITERIA NEEDS TO BE MET TO QUALIFY FOR SYNAGIS® - IF RESPONSE IS YES TO ANY OF THE FOLLOWING 3 QUESTIONS - THE CHILD QUALIFIES FOR SYNAGIS®

- 1. Is the child less than 24 mths (as of Nov 1, 2011) and has had bronchopulmonary dysplasia/chronic lung disease...
2. Is the child less than 24 mths with hemodynamically significant congenital heart disease...
3. PREMATURITY: A. Was child born at less than 29 weeks gestation... B. Was child born 29 - 32 weeks of gestation... C. Was child born between 32 - 35 weeks gestation...

Additional Information Required for Processing: A. NICU History: B. Was there an NICU/Hospital dose administered? C. Are there other medical reasons or diagnosis such as severe neuromuscular disease...

RX section: Synagis® (palivizumab) 50 and/or 100 mg vials, Epinephrine 1:1000 amp, Other Medications, Known Allergies, Prescriber's Signature.

RX: Refills Monthly Nov 1, 2011 to March 31, 2012

FOR NHPRI USE ONLY:

4 Auth#: Approved By: Date: # Injections Approved: Start Date: Thru Date: