



Prior Authorization decision will be made within 24 hours.					
Request Date:			<input type="checkbox"/> Urgent/Expedited		
This medication will be administered by <input type="checkbox"/> Patient/Caregiver <input type="checkbox"/> Pharmacist <input type="checkbox"/> Other Healthcare Provider At: <input type="checkbox"/> Home <input type="checkbox"/> Long-Term Care Setting (NF/ICF) <input type="checkbox"/> Hospice <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other					
Patient Name (Last, First)		Patient DOB (MM/DD/YYYY)		Patient Medicaid ID Number	
		/ /			
<input type="checkbox"/> Male <input type="checkbox"/> Female	Gestational Age:		Birth Weight(kg)	Current Weight(kg)	Age as of November 1st
	Weeks	Days			
Prescriber Full Name (Last, First)			Prescriber Address		
Prescriber NPI Number		Prescriber Phone Number		Prescriber Fax Number	
		() -		() -	
(If Known) Pharmacy Name				Pharmacy Phone Number	
				() -	

DIAGNOSIS AND PATIENT HISTORY (CHECK ALL THAT APPLY)

<input type="checkbox"/> Prematurity (<i>gestational age 28 weeks, 6 days or less</i>) <input type="checkbox"/> Chronic lung disease of prematurity during 1st year of life (<i>< 12 months of age</i>) ICD-10 code required <32 weeks GA requiring >21% of oxygen for at least the first 28 days after birth. <input type="checkbox"/> Chronic lung disease of prematurity during 2nd year of life (<i>< 24 months of age</i>) ICD-10 code required <32 weeks GA requiring >21% of oxygen for at least the first 28 days after birth. Requirement of continued medical support (e.g. chronic corticosteroid, bronchodilator, or diuretic therapy; supplemental oxygen) during 6-month period before start of second RSV season.
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Treatment

Oxygen (dates/duration)	Steroids (dates/duration)
Bronchodilators (dates/duration)	Diuretics (dates/duration)
<input type="checkbox"/> Hemodynamically significant CHD during 1 st year of life (<12 months of age) ICD-10 code required	
Diagnosis of hemodynamically significant acyanotic CHD? <div style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</div>	Diagnosis of hemodynamically significant cyanotic CHD? <div style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</div>
Consultation with a pediatric cardiologist regarding palivizumab? <div style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</div>	Diagnosis of moderate-to-severe pulmonary HTN? <div style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</div>
List of medications used to control CHF	
<input type="checkbox"/> Severe neuromuscular disease (<12 months of age) ICD-10 <input type="checkbox"/> Congenital abnormalities of airways (<12 months of age) ICD-10 <input type="checkbox"/> Immunosuppressive/autoimmune disease (≤ 24 months of age) ICD-10 code required: <input type="checkbox"/> Receiving chemotherapy (check if patient is receiving chemotherapy) <input type="checkbox"/> Undergoing cardiac transplantation (< 24 months of age) Date <input type="checkbox"/> Other	

Fax To: Gainwell Technologies, Attention: PA Helpdesk
Fax: (833) 679-5491 Phone: (833) 491-0344 (TTY 833-655-2437)
Hours: Monday – Friday 8:00 am – 8:00 pm EST

RX info: Synagis (palivizumab) 50mg and/or 100mg vials Directions: Inject 15mg/kg IM one time per month

Number of Doses

Date of first injection

Quantity of Refills

☐ I attest that I am a member of the prescriber's office in accordance with 5160-9-03 or 5160-26-03, as applicable. Only the prescribing provider or a member of the prescribing provider's staff may request prior authorization.

Prescriber's Signature (or staff of prescriber & PRINTED name)

Date