Humana®

SYNAGIS Prior Authorization Worksheet/Prescription Form

Please FAX or MAIL this completed form to:
CareSource, Attn: Specialty Pharmacy
P.O. Box 1307, Dayton, OH 45401-1307
Fax: 1-888-399-0271
1-855-852-7005

Patient Information (Bold Items Are Required)

Patient's (Child's) Name ____________ ☐ **M** ☐ **F** **DOB** ________
Gestational Age (GA) ______ **Weeks** ______ **Days** **Birth Weight** ______ **lb/kg** **Current Weight** ______ **lb/kg** **Date** ________
Patient's Address ____________
City/State/Zip ____________
Phone Number (_______) ____________
Parent's Name ____________
Member I.D. Number ____________ Other Insurance ____________

Synagis criteria are based on 2009 American Academy of Pediatrics Guidelines. Medical Authorization Clinical Criteria (Please check ALL that apply.)

Infant/Child's Condition:

☐ ≤ 28 6/7 weeks GA (≤ 12 months of age at start of RSV season) [5 dose max]
☐ ≤ 29 0/7 weeks - 31 6/7 weeks GA (≤ 6 months of age at start of season) [5 dose max]
☐ ≤ 32 0/7 weeks - 34 6/7 weeks GA (< 3 months of age at start of RSV season); check all risk factors that apply [3 dose max up to age 90 days]
☐ Other (Explain): ____________

Risk Factors Consideration:
☐ Siblings < 5 years of age
☐ On O_2/Airway Support
☐ Child in Day Care

Diagnosis of Consideration: (Please check ALL that apply.)
☐ Immunosuppressive/Autoimmune Disease
☐ Severe Neuromuscular Disease
☐ Congenital Abnormalities of Airways
☐ Other ____________

Please note:
Risk Factors for Consideration are subject to clinical and medical review

☐ 770.7

(Please document treatment and attach supporting documentation) →

Chronic Lung Disease/BPD: Infants and Children ≤ 24 month with Chronic Lung Disease (CLD) who have received treatment for the medical condition in the 6 months prior to RSV season.

Diagnosis: ____________

Treatment:

Mechanical ventilation:	Yes / No	Days / Duration ____________
Supplemental oxygen:	Yes / No	Days / Duration ____________
Steroids and/or diuretics:	Yes / No	Days / Duration ____________
Other	Yes / No	Days / Duration ____________

☐ ______ (745-747)

Cardiac (CHD): Infants and Children ≤ 24 month with **hemodynamically significant** cyanotic and acyanotic heart disease:
- With moderate to severe pulmonary hypertension -747.83 or _____
- With cyanotic cogenital heart disease -746.9 or _____
- Who are receiving medication to control congestive heart failure -779.89 _____ List Medications ____________
- Other ____________ Dx ICD-9 ____________

Comments ____________

Drug Claim to be Submitted by:
☐ Prescribing Physician
☐ Dispensing Pharmacy
☐ CVS Caremark (preferred)
☐ Other

Dispensing Pharmacy ____________
Address ____________
City/State/Zip ____________
Contact Name ____________ Phone ____________
Tax ID # ____________ Fax ____________

Drug Claim to be submitted to:
☐ Medical Benefit
☐ Pharmacy Benefit

Place of Service:
☐ Physician's Office ☐ Member's Home, Administered by ____________ ☐ Synagis Clinic ☐ CareSource to Arrange

Prescribing Physician:
Physician Name ____________ Prescriber Specialty ____________
Office Contact ____________ Phone ____________ Fax ____________
Facility ____________ Address ____________
City/State/Zip ____________
License # ____________ DEA # ____________ NPI # ____________

Approved Prior Authorizations are contingent upon the eligibility of member at the time of service and the claim timely filing limits.
Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent upon eligibility and benefits.

KY-P-11, November 2012