BlueCross BlueShield Nebraska

SYNAGIS® PREAUTHORIZATION
Physician Fax Form

Date: ____________________

Patient Information

Patient Name (First):	(Last):	MI:	Sex: ☐ M ☐ F	Date of Birth (mm/dd/yyyy):
Address (Street): (City) (ST) (Zip)		Day Phone:		Evening Phone:
Caregiver/Emergency Contact Name:		Relationship To Patient:		Phone:

Insurance Information

Blue Cross and Blue Shield of Nebraska ID:

Physician Information

Physician Name:	Clinic Name:		Office Contact:
Address (Street, City, St, Zip):	License:	UPIN:	NPI:
	Phone:	Secure Fax Number:	
Specialty:			

Statement of Medical Necessity

Coverage of Synagis® is approved for infants or children who meet criteria for high risk of RSV disease.

1. Does the patient have a diagnosis of an immune deficiency? .... ☐ Yes ☐ No ICD10-CM Code: ____________
2. Does the patient have a diagnosis of congenital heart disease (CHD)? .... ☐ Yes ☐ No ICD10-CM Code: ____________
   If yes, is the patient receiving medication for CHD? .... ☐ Yes ☐ No
   Medications prescribed: ____________
3. Does the patient have a diagnosis of chronic lung disease, including requiring > 21% oxygen for at least the first 28 days after birth? .... ☐ Yes ☐ No ICD10-CM Code: ____________
   (Chronic respiratory disease arising in the perinatal period i.e. bronchopulmonary dysplasia, interstitial pulmonary fibrosis of prematurity, Wilson Mikity syndrome), (P27.8 Other respiratory conditions of fetus and newborn)
   If yes, has the patient required medical therapy within six months prior to the beginning of RSV seasons? ☐ Yes ☐ No
   Please indicate therapy required: ☐ Oxygen ☐ Bronchodilator ☐ Diuretic ☐ Corticosteroid ☐ Other: ____________
4. The patient was born at what gestational age? ____________
   ICD10-CM Code for > 37 completed weeks gestation use: Z38.0

   ICD10-CM Code for Extreme Immaturity of newborn: P07.2 ____________ *
   *Use the following fifth digit sub classification for categories to denote weeks of gestation completed
   [0] unspecified weeks [1 <23 completed weeks [2] 23 completed weeks [3] 24 completed weeks
   [4] 25 completed weeks [5] 26 completed weeks [6] 27 completed weeks

   ICD 10-CM Code for Preterm Newborn: P07.3 ____________ *
   *Use the following fifth digit sub classification for categories to denote weeks of gestation completed
   [0] unspecified weeks [1] 28 completed weeks [2] 29 completed weeks [3] 30 completed weeks [4] 31 completed weeks
   [5] 32 completed weeks [6] 33 completed weeks [7] 34 completed weeks [8] 35 completed weeks [9] 36 completed weeks

5. Has the patient undergone a heart transplant during the RSV season? .... ☐ Yes ☐ No Date of Transplant: ____________
6. Does the patient have a diagnosis of congenital abnormalities of the airways? .... ☐ Yes ☐ No ICD10-CM Code: ____________
7. Does the patient have a diagnosis of severe neuromuscular disease? .... ☐ Yes ☐ No ICD10-CM Code: ____________
8. Please include any additional information that should be considered with this review: ____________

Medical History

Allergies: ☐ NKDA	Ht: ______ ☐ in ☐ cm Date: ______	Wt: ______ ☐ kg Date: ______

Prescription And Orders: All approved requests will be forwarded to Prime Specialty Pharmacy; if another provider is requested, CHECK THIS BOX ☐

Synagis® (palivizumab) Is this the first dose? ☐ Yes ☐ No If no, date first dose given: ____________________

☐ Start ASAP ☐ Next dose due: ____________________

☐ Administer 15 mg / kg / month intramuscularly: Duration: __________ months (not including previous doses)

☐ Administer __________mg / kg / month intramuscularly: Duration: __________ months (not including previous doses)

☐ Sterile water for injection and supplies needed for administration

Pediatric Anaphylaxis

☐ Administer 0.01 ml/kg (max 0.3ml) of 1:1000 epinephrine solution SUBCUTANEOUSLY or INTRAMUSCULARLY, and contact EMS or physician, as appropriate.

Physician will monitor patient's response to therapy. Any complications in therapy will be reported to physician either by patient's caregiver, Prime Specialty Pharmacy or the skilled nursing service company (if other than physician's office or Prime Specialty Pharmacy).

Other orders:

Physician's Signature: **Date:**

Please fax or mail this form to:
Blue Cross and Blue Shield of Nebraska
Pharmacy Department - UM
1919 Aksarben Drive • PO Box 3248
Omaha, NE 68180-0001

Toll-Free Fax: 877.232.6726
Phone: 877.999.2374

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