BlueCross BlueShield Nebraska

SYNAGIS® PREAUTHORIZATION POLICY X.4
Physician Fax Form

Only the prescriber may complete this form for prospective reviews.
The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit NebraskaBlue.com. *Start saving time by filling out this preauthorization electronically at* Visit MedicalPolicy.NebraskaBlue.com.

What is the priority level of this request?

☐ Standard review - Completed within 15 calendar days of receipt.

☐ Expedited/Urgent review - If the standard time period for a decision could seriously jeopardize the life or health of patient could not be adequately managed; completed within 72 hours of receipt.

Patient Information

Date:

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: _____

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 attach any additional information that should be considered with this request

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

Toll-Free Fax: 877.232.6726
Phone: 877.999.2374