SYNAGIS
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

ONLY the prescriber may complete and fax this form. This form is for prospective, concurrent, and retrospective reviews.

Incomplete forms will be returned for additional information. The following documentation is required for prior authorization consideration. For formulary information and to download additional forms, please visit https://www.bcbstx.com/provider/medicaid/pharmacy/star-kids-prior-auth

PATIENT AND INSURANCE INFORMATION **Today's Date:** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):
Patient Address:	City, State, Zip:	Patient Telephone:	
BCBSTX ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis

☐ Hemodynamically significant congenital heart disease (CHD):

☐ Other diagnosis, please include ICD code and description:

Medication Requested: Strength:

Dosing Schedule: Quantity per Month:

Birth Weight: _____kg or _____lb Current Weight: _____ kg or _____ lb Date recorded: _____

☐ Syringes 1ml 25G 5/8" ☐ Syringes 3ml 20G 1" ☐ Epinephrine 1:1000 amp Sig: inject 0.01 mg/kg as directed

For All Requests:

1. Is the patient currently treated with the requested medication?..... ☐ Yes ☐ No
   If yes, when was treatment with the requested medication started?_____
2. Will the requested medication be used during the patient's current RSV season? Refer to schedule at: https://www.txvendordrug.com/about/news/2023/2023-24-rsv-season-schedule..... ☐ Yes ☐ No
   Please indicate the patient's age at the start of Respiratory Syncytial Virus (RSV) season: _____
   Please indicate the patient's gestational age: _____ weeks and _____/ 7th day
3. Has patient received a Synagis prophylactic injection during a hospitalization since the start of the current RSV season? ..... ☐ Yes ☐ No
   If yes, number of injections: _____ Dose (mg): _____ Date(s): _____
4. Has the patient had a dose of Beyfortus during during the current RSV season?..... ☐ Yes ☐ No
   If yes, date Beyfortus given: _____
5. Has Abrysvo been given to the patient's mother during 32 through 36 weeks gestational age of pregnancy? ..... ☐ Yes ☐ No
   If yes, date Abrysvo given: _____
6. Has the patient been hospitalized due to RSV at any time since the start of the current RSV season?..... ☐ Yes ☐ No
   If yes, please provide date of diagnosis: _____
7. Please list all other medications the patient is **currently taking** for the treatment of this diagnosis. _____
   _____
   _____
8. Please list all reasons for selecting the **requested medication** over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried). _____
   _____
   _____

Please continue to the next page.

Patient name (First):	Last:	M:	DOB (mm/dd/yy):

9. Please list all medications the patient has **previously tried and failed** for treatment of this diagnosis. (Please specify if the patient has tried brand-name products, generic products, or over-the-counter products.)

_____ Date(s): _____ _____ Date(s): _____

_____ Date(s): _____ _____ Date(s): _____

_____ Date(s): _____ _____ Date(s): _____

*Patients **younger than 12 months** chronological age at the start of the RSV season can qualify for up to 5 monthly doses of Synagis, based on criteria listed below. ***Diagnoses and conditions must be clearly documented in the patient's medical record.***

(Please check all that apply)

☐ Hemodynamically significant congenital heart disease (CHD)
☐ Patient was less than or equal to (≤) 28 6/7 weeks' gestational age at birth
☐ Chronic lung disease (CLD) of prematurity (Patient's gestational age must be ≤ 31 6/7 weeks at birth)
☐ Severe congenital abnormality of airway
☐ Severe neuromuscular disease compromising the handling of respiratory tract secretions
☐ Moderate-to-severe pulmonary hypertension
☐ Acyanotic heart disease and will require cardiac surgery (Patient must have a paid claim for a heart disease drug in the last 60 days)
☐ Cyanotic heart disease
☐ Diagnosis of cystic fibrosis with clinical evidence of CLD and/or nutritional compromise
☐ An identified disease state that will leave the patient profoundly immunocompromised during the RSV season
☐ Patient had a solid organ or hematopoietic stem cell transplant during the RSV season

*Patients **12 months of age or older AND younger than 24 months** chronological age at start of RSV season can qualify for up to 5 monthly doses of Synagis, based on the criteria listed below. ***Diagnoses and conditions must be clearly documented in the patient's medical record.*** **(Please check all that apply)**

☐ Chronic lung disease (CLD) of prematurity. Patient's gestational age must be ≤ 31 6/7 weeks at birth. The patient must have required at least one of the following therapies within the last 180 days (check all that apply):

- ☐ Chronic use of systemic corticosteroids
- ☐ Supplemental oxygen
- ☐ Long-Term Mechanical Ventilator
- ☐ Diuretics

☐ Diagnosis of cystic fibrosis with severe lung disease, or, cystic fibrosis with weight less than the 10th percentile

☐ An identified disease state that will leave the patient profoundly immunocompromised during the RSV season

☐ Patient had a solid organ or hematopoietic stem cell transplant during the RSV season

Prescriber or Authorized Signature: _____ Date: _____

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility Authorization does not guarantee payment.

Please fax or mail this form to:
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Eagan, Minnesota 55121

TOLL FREE
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