



For Internal Use Only
PA#:
Date Entered:

SYNAGIS Referral Form

**FAX Completed Form & Prescription to:
(410) 424-4607**

Questions? Contact the Pharmacy Dept at:
410-424-4490, option 4
or 1-888-819-1043, option 4

Patient Information	Physician Information
Member Name: _____	Physician Name : _____
Member ID: _____	Office Contact: _____
Date of Birth: _____	Office Phone: _____
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Office Fax: _____
Parent/Guardian: _____	DEA # _____

Prescription Information (Prescription for Synagis MUST be attached)

Synagis Vial Quantity: 100mg: _____ 50 mg: _____	NICU dose administered? <input type="checkbox"/> No <input type="checkbox"/> Yes, Date(s): _____
SIG: Inject 15mg/kg IM one time per month	Birth Weight: _____ lbs or kg (circle one)
Desired Start Date: _____ Refill: _____ months	Current Weight: _____ lbs or kg (Required)

Diagnosis Information

<input type="checkbox"/> Extreme Prematurity (< 27 wks of gestation)	<input type="checkbox"/> Congenital Heart Disease
<input type="checkbox"/> Prematurity (28-37 weeks of gestation)	<input type="checkbox"/> Other ICD-9 specify: _____
<input type="checkbox"/> Chronic Respiratory Disease arising in the neonatal or perinatal period (CLD)	Actual Gestational Age: _____ weeks (Required)

Approval Criteria (If applicable, attach NICU discharge summary and/or supporting progress notes)

<input type="checkbox"/> 28 wks or less gestation and less than 12 months of age at beginning of RSV season
<input type="checkbox"/> 29 wks - 31 wks 6 days gestation and less than 6 months of age at beginning of RSV season
<input type="checkbox"/> 32 wks - 34 wks 6 days gestation and less than 3 months of age at beginning of RSV season plus one of the following risk factors:
<input type="checkbox"/> daycare attendance <input type="checkbox"/> sibling(s) less than 5 yrs of age living in the home
<input type="checkbox"/> Less than 12 months of age with diagnosis of CLD (e.g., bronchopulmonary dysplasia, BPD)
<input type="checkbox"/> Less than 24 months of age with CLD requiring treatment with one of the following: <input type="checkbox"/> oxygen <input type="checkbox"/> diuretics <input type="checkbox"/> chronic bronchodilator requirement <input type="checkbox"/> chronic corticosteroid therapy
<input type="checkbox"/> Tracheotomy patient less than 24 months of age with pulmonary disease
<input type="checkbox"/> Less than 34 wks 6 days gestation and less than 12 months of age at beginning of RSV season plus one of the following: <input type="checkbox"/> congenital airway abnormality <input type="checkbox"/> neuromuscular condition that compromises handling of secretions
<input type="checkbox"/> Less than 24 months of age with cyanotic/acyanotic CHD plus one of the following: <input type="checkbox"/> receiving medication to control CHF <input type="checkbox"/> moderate to severe pulmonary hypertension
<input type="checkbox"/> Less than 12 months of age with severe immunodeficiency

I certify that the clinical information provided on this form is complete and accurate.

Provider Signature: _____ **Today's Date:** _____

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Approved:	Duration of Approval:
*Denied:	Authorized By:
Incomplete/Other:	Name:

***Send all appeals to Priority Partners. DO NOT send appeals to the pharmacy vendor.**