



Physician Request Form for Synagis® 2010-2011 season

Fax to Mercy Health Plans Prior Authorization at 314-214-8201 or 800-466-9854. To speak to a Mercy Health Plans representative call (314) 214-8282 or (800) 647-2240. (Forms not filled out appropriately could result in denial and/or subsequent delays in Synagis delivery.)

Patient Last Name		Patient First Name		Mercy ID #	DOB
Street Address				Parent/Guardian	
City	State	Zip	Home Phone Number	Gender	

Gestational Age:	Birth Weight:	Multiple Births? Y N Number _____
Chronological Age:	Current Weight:	Was there a NICU/Hospital dose administered? Y N Date _____

Please check the appropriate box and submit clinical information from the pediatrician/specialist including current treatment for children with chronic lung disease (CLD) or congenital heart disease (CHD).

**FIRST Season RSV Prophylaxis Prior Authorization Synagis (palivizumab)**  
 \*\*\*Please submit copies of hospital discharge summary for all first season requests

<input type="checkbox"/> <b>≤28wk 6d Gestational Age</b> and DOB 11/01/2009 or later	<input type="checkbox"/> <b>29wk 0d through 31wk 6d Gestational Age</b> and DOB 05/01/2010 or later
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**32wk 0d through 34wk 6d Gestational Age** and have

Severe neuromuscular disease                       Congenital abnormalities of the airway

or have a DOB after 08/01/2010 and have one of the following AAP risk factors

School age siblings <5 years of age                       Daycare Attendance: \_\_\_\_\_ days a week

<input type="checkbox"/> Chronic Lung Disease (CLD) Dx code: _____ DOB 11/01/2009 or later and medical therapy for CLD  <input type="checkbox"/> Supplemental O2 therapy, <input type="checkbox"/> Bronchodilators, <input type="checkbox"/> Diuretics, <input type="checkbox"/> Other _____	<input type="checkbox"/> Congenital Heart Disease (CHD) Dx code: _____ DOB 11/01/2009 or later and hemodynamically significant heart disease including but not limited to  <input type="checkbox"/> Moderate to severe pulmonary hypertension <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Cyanotic heart disease/hypoxia <input type="checkbox"/> Anticipated surgery during RSV season requiring cardiopulmonary bypass
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**SECOND Season RSV Prophylaxis Prior Authorization Synagis (palivizumab)**

<input type="checkbox"/> Chronic Lung Disease (CLD) Dx code: _____ DOB 11/01/2008 or later and medical therapy for CLD  <input type="checkbox"/> Supplemental O2 therapy, <input type="checkbox"/> Bronchodilators, <input type="checkbox"/> Diuretics, <input type="checkbox"/> Other _____	<input type="checkbox"/> Congenital Heart Disease (CHD) Dx code: _____ DOB 11/01/2008 or later and hemodynamically significant heart disease including but not limited to  <input type="checkbox"/> Moderate to severe pulmonary hypertension <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Cyanotic heart disease/hypoxia <input type="checkbox"/> Anticipated surgery during RSV season requiring cardiopulmonary bypass
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Synagis® Vendors: ICORE **p**    Accredo **p**    Caremark **p**    OptionCare **p**    Nursing Specialties **p**  
 Deliver Product to: Office **p**    Patient's Home **p**    Home Health Agency (*Home administration will require a letter of medical necessity*) **p**

Was there a NICU/HOSPITAL dose administered? Yes <b>p</b> No <b>p</b> Date: _____
Is this a continuation from a previous insurance? Yes <b>p</b> No <b>p</b> Date of last dose: _____
Physician Name: _____ Office Contact: _____
Mailing Address: _____ Phone Number: _____
City: _____ State: _____ Zip: _____ Fax Number: _____
Physician Signature: _____ (medically necessary)    Number of doses being requested: _____