MC-Rx
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Synagis® palivizumab

Ticket #: _____ **Request Date:** _____ **Request Time:** _____

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

Synagis® palivizumab will be approved for payment for eligible clients that are currently less than 2 years old and either currently have chronic lung disease or based on gestational age have a high risk for RSV. This medication will only be approved for payment during the RSV season (the RSV season typically commences in October/November and lasts through April/May) and will not be approved for payment for second season prophylaxis unless the client has chronic lung disease requiring medical therapy. Please fill out the following information and return to us as indicated below:

A. Member Information		
Patient Name:	Plan Name/Plan ID:	
Patient ID:	Patient Date of Birth:	Patient Contact Phone #:

B. Physician Information			
Physician Name:	Physician Address:		
Physician DEA #:	Physician Phone #:	Physician Fax #:	
Drug Name and Strength:	Direction (SIG):	QTY and Days Supply:	NDC #:

C. Pharmacy Information			
Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:

D. Clinical Information (Please fill out the following information: circle all that apply)

Patient's Current Age:
- ☐ 24 months
- ☐ 6-12 months
- ☐ 13-23 months
- ☐ 6 months

Patient Gestational Age at Birth:
- ☐ <29 weeks
- ☐ 29-32 weeks
- ☐ 33-35 weeks
- ☐ Other: _____ weeks

Patient's Weight: (in KG)

_____ (1 Kg= 2.2 Lbs)

1. Has the patient been treated for chronic lung disease within the last six months? YES NO
2. Patient Risk Factors (check all that apply)
   - ☐ Congenital heart defects (acyanotic)
   - ☐ More than 1 young sibling
   - ☐ Child care center attendance
   - ☐ Anticipated cardiac surgery
   - ☐ Long distance from hospital care
   - ☐ Neurological disease
   - ☐ Low birth weight
   - ☐ Exposure to tobacco smoke
3. Is this the first time the patient is being prophylaxed with Synagis? YES NO

Dosing Guidelines: 15 mg/Kg IM qmonth throughout RSV season (dose per month = weight (Kg) x 15 mg/Kg ÷ 100 mg/ml (of palivizumab)

Authorized Medical Signature:	
Telephone:	**Date:**

When Completed Return To:

MC-Rx Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

**Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes.