

SYNAGIS

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

CURASCRIP PHARMACY SERVICES
UPMC HEALTH PLAN PHARMACY SERVICES

PHONE: 866-297-0933
PHONE: 800-979-8762

FAX: 866-297-0934
FAX: 412-454-7722

PLEASE TYPE OR PRINT NEATLY

Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.

PATIENT INFORMATION

| | | |
|----------------------|-------------------------------------|--------------|
| Office Contact: | Provider Specialty: | |
| Provider First Name: | Provider Last Name: | |
| Provider Phone: | Provider Fax: | |
| Patient Name: | Patient UPMC Health Plan ID Number: | Patient DOB: |

Place of infusion? (Name and Location) Physician's Office:
 Other (please specify):

PRIMARY DIAGNOSIS

| | | | |
|---|--|--------------------------------------|--|
| Patient Gestational Age (GA): | Birth Weight: | Current Weight: | Date Recorded |
| Chronic Lung Disease <input type="checkbox"/> Yes (Specify) _____ <input type="checkbox"/> No | | | |
| Therapies used within the last 6 months (Check all that apply) | | | |
| <input type="checkbox"/> Supplemental O ₂ | <input type="checkbox"/> Bronchodilator(s) | <input type="checkbox"/> Diuretic(s) | <input type="checkbox"/> Corticosteroid(s) |
| Hemodynamically significant congenital heart disease <input type="checkbox"/> Yes (Specify) _____ <input type="checkbox"/> No | <input type="checkbox"/> CHF | | |
| | <input type="checkbox"/> Cyanotic disease | | |
| | Other _____ | | |
| List medications used _____ | | | |

RISK FACTORS

Clinically has the following risk factors (check all that apply):

School age siblings younger than 5 yrs old Day care attendance Other

NICU HISTORY

NICU dose given, date _____

RX

RX Synagis (palivizumab) 50 mg and/or 100 mg vials Directions: Administer 15 mg/kg IM once monthly
Quantity: QS Refill _____ Needs by _____
Prescriber's signature (substitution permissible) _____ Date: _____

***In order for a brand name product to be dispensed, the physician must handwrite "Brand Medically Necessary" in the space provided.

Deliver product to: Physicians Office Patient's Home