UPMC Health Plan

SYNAGIS

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, call UPMC Health Plan Pharmacy Services.
Otherwise, please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES **PHONE: 1-800-979-UPMC (8762)** **FAX: 412-454-7722**
CURASCRIPT/ACCREDO PHARMACY SERVICES **PHONE: 1-866-297-0933** **FAX: 1-866-297-0934**

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.

Office Contact:	**Provider Specialty:**
Provider First Name	**Provider Last Name:**
Provider Phone #:	**Provider Fax #:**

Patient Name:	**Patient UPMC Health Plan Member ID #:**	**Patient DOB:**	**Patient Age:**
Patient Gestational Age (GA):	**Birth Weight (provide units):**	**Current Weight (provide units):**	**Date Recorded:**
Strength:	**Frequency:**	**Quantity Dispensed (including units):**	

Diagnosis:

Please indicate place of administration: ☐ Physician's Office ☐ Hospital/Facility ☐ Patient Home ☐ Other

Please provide hospital/facility information:
Name: _____
Phone #: _____
Address: _____
_____

Will the medication be (select one):
☐ Billed directly by the provider via JCODE
JCODE: _____
☐ Billed by a pharmacy and delivered to the provider
Pharmacy name: _____
☐ Billed by a pharmacy and delivered to the patient
Pharmacy name: _____

PRIMARY DIAGNOSIS

Does the patient have Chronic Lung Disease of prematurity? ☐ Yes ☐ No

If yes, has the patient required more than 21% supplemental oxygen? ☐ Yes ☐ No

Please provide dates of oxygen therapy: _____

Please indicate if any of the following therapies were used within the past 6 months for the above diagnosis (check all that apply):
☐ Supplemental oxygen ☐ Diuretics ☐ Corticosteroids ☐ None

Does the patient have hemodynamically significant Congenital Heart Disease? ☐ Yes ☐ No

If yes, please specify the diagnosis:
☐ Acyanotic heart disease that will require cardiac surgery
☐ Moderate to severe pulmonary hypertension
☐ Cardiac lesion adequately corrected by surgery
☐ Other: _____

Does the patient have a neuromuscular disease or congenital anomaly that impairs the ability to clear secretions from the airway due to ineffective cough? ☐ Yes ☐ No

If yes, please indicate specific diagnosis: _____

Is the patient profoundly immunocompromised? ☐ Yes ☐ No

If yes, please specify reason:
☐ Severe combined immunodeficiency syndrome
☐ Severe acquired immunodeficiency syndrome
☐ Acute lymphoblastic leukemia
☐ Hematopoietic stem cell transplant
☐ Severe T-cell deficiency
☐ Acute myeloid leukemia
☐ Receiving chemotherapy
☐ Other

Please be sure to complete and include the 2nd page of this form.

SYNAGIS
Page 2

Patient Name	Patient UPMC Health Plan ID Number:	Patient DOB:

Please be sure to complete and include this page with the 1st page of this form.

Does the patient have cystic fibrosis? ☐ Yes ☐ No

If yes, does the patient have clinical evidence of chronic lung disease and/or nutritional compromise? ☐ Yes ☐ No

Has the patient had any of the following?
- ☐ Previous hospitalization for pulmonary exacerbation in first year of life
- ☐ Abnormalities on chest radiography or chest computed tomography that persist when stable
- ☐ Weight for length less than -10th percentile

Has the patient had a heart transplant? ☐ Yes ☐ No

If yes, please provide the date of the transplant: _____

Please list all medications the patient currently is using or has used in the past for the any of the above diagnoses

Medication Name	Start Date	End Date	Strength	Frequency	Reason for failure or discontinuation:

Synagis Dosing History

Was a NICU dose given? ☐ Yes (specify date) _____ ☐ No

Has the patient received any other non-NICU doses during this RSV season? ☐ Yes ☐ No

Please provide any additional information which should be considered in the space below: