MASSACHUSETTS STANDARD FORM FOR SYNAGIS® PRIOR AUTHORIZATION REQUESTS

**Some plans might not accept this form for Medicare or Medicaid requests.*

A. Destination		
Health Plan or Prescription Plan Name: **Tufts Health Plan, Attn: Pharmacy Utilization Management Department**		
Health Plan Phone: **1.888.257.1985**	Health Plan Fax: **1.617.673.0988**	**Online Prior Authorization: https://point32health.promptpa.com**

B. Patient Information		
Patient Name:	DOB:	Gender: ☐ Male ☐ Female ☐ Other: _____
Member ID #:		

C. Prescriber Information	
Prescribing Clinician:	Phone #:
Specialty:	Secure Fax #:
NPI #:	DEA #:
Prescriber Point of Contact (POC) Name (if different than prescriber):	
POC Phone #:	POC Secure Fax #:
POC Email (not required):	
Prescribing Clinician or Authorized Representative Signature:	
Date:	

D. Medication Information — SYNAGIS® (palivizumab)

Check if Expedited Review/Urgent Request:
☐ (In checking this box, I attest to the fact that this request meets the definition and criteria for expedited review and is an urgent request.)

Is the patient currently being treated with the drug requested? ☐ Yes ☐ No

If yes, date started: _____ Date of last dose received: _____ Number of doses received: _____

Number of doses requested: _____

E. Patient Clinical Information

Primary Diagnosis Related to Medication Request:

ICD Code(s):

Gestational age: # weeks: _____ # days: _____

Birth weight: _____ Current weight: _____ Date current weight recorded: _____

Pertinent Concurrent Medications:

Allergies:

(continued on next page)

Clinical Conditions (2014 AAP Committee on Infectious Disease and Bronchiolitis Guidelines)	
Chronic Lung Disease (CLD)	CLD of prematurity defined as gestational age ≤31 weeks, 6 days, AND requirement for 21% oxygen for at least the first 28 days after birth ☐ <12 months of age with CLD ☐ 12–24 months of age with CLD AND continues to require medical support during the 6-month period before second RSV season AND ☐ Supplemental oxygen (dates): _____ ☐ Diuretic therapy (drugs/dates): _____ ☐ Chronic corticosteroids (drugs/dates): _____ ☐ Other _____ **Chronic Respiratory Disease arising in the perinatal period:** ☐ Wilson-Mikity Syndrome (P27.0) ☐ Bronchopulmonary Dysplasia originating in the perinatal period (P27.1) ☐ Other chronic respiratory disease originating in the perinatal period (P27.8) **Congenital Abnormality of the Lungs:** _____
Congenital Heart Disease (CHD)	☐ <12 months of age at start of season with hemodynamically significant CHD such as: ☐ Acyanotic heart disease and receiving medication to control congestive heart failure and surgery to correct (drugs/dates): _____ (surgery date): _____ ☐ Moderate to severe pulmonary hypertension ☐ Other (describe): _____ ☐ 12–24 months of age undergoing cardiac transplant during RSV season (date of planned surgery): _____ ☐ Cyanotic Heart Disease — Diagnosis: _____
Airway/Neuromuscular Conditions	☐ <12 months of age at start of season and compromised handling of secretions AND due to: ☐ Significant abnormality of the airway (attach clinical notes) ☐ Neuromuscular condition (attach clinical notes)
Prematurity	☐ ≤GA 28 weeks, 6 days AND <12 months at start of season
Other medical conditions or history	☐ Cystic Fibrosis ☐ Down's Syndrome ☐ Immunocompromised ☐ Describe other relevant medical history: _____

Complete this section for Professionally Administered Medications (including Buy and Bill)	
Start Date:	End Date:
Servicing Prescriber/Facility Name:	☐ Same as Prescribing Clinician
Servicing Provider/Facility Address:	
Servicing Provider NPI/Tax ID #:	
Name of Billing Provider:	
Billing Provider NPI #:	
Is this a request for reauthorization? ☐ Yes ☐ No	
CPT Code: _____ # of Visits: _____ J Code: _____ # of Units: _____	

Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers may attach any additional data relevant to medical necessity criteria.