	SYNAGIS Prior Authorization Please FAX this completed form to: 866-930-0019 for Pharmacy Benefit or 888-399-0271 for Medical Benefit	SYNAGIS® (palivizumab)

Patient's (Child's) Name:_____ ..M ..F Date: _____
Gestational Age of Birth: Weeks ___ Days____ Birth Weight: _____lb/kg Current Weight:____lb/kg DOB: _____
Patient's Address: _____
City/State/Zip: _____
Phone Number: (___)_____Parent's Name: _____
Primary Insurance:_____ID#_____
Secondary Insurance:_____ID#_____

Is this a multiple birth (twins, triplets, etc.)? …Yes …No

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Chronic Lung Disease R I 3 U H P D W. X U L W \
Diagnosis/ICD-01 _____
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v /(‰ š] vš]• Œ]À]vP u] o šŒ šu všU Z l oo šZ š ‰‰oÇ
… Oxygen (dates _____ __)
… Corticosteroid _____ (dates _____ z)
W o • o]•š ŒµP~••W zzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzz
… Diuretic _____ (dates _____)
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Documented diagnosis must be confirmed by the individual's medical record and will need to be supplied with the prior authorization request. These medical records may include, but are not limited to test reports, chart notes from provider's office or hospital admission notes.

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Diagnosis/ICD-01 _____
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Was there a hospital/NICU dose given? ☐ ☐ _____

Drug Claim to be