American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Through the efforts of the New Mexico AAP Chapter pediatric council, all payers agreed to use the Chapter developed universal Prior Authorization Form/Statement of Medical Necessity for the administration of Synagis for RSV prophylaxis.

Attached is the form

Synagis Prior Authorization/Statement of Medical Necessity/Order Form

BCBS Blue Salud Lovelace Molina Presbyterian United Health Other **Today's Date:**

Patient Name	**Gender:**	**DOB:**	**Child's Wt. (current Kg)**
Insurance ID/SS#:		Parent/Guardian Name:	
Address:			
Phone:		Phone 2:	
Insurance:		Insurance 2:	
Provider's Name:			
Provider's Address:			
Provider's Phone:		Provider's Fax:	

NICU Graduate: Yes_______ No_______ Unknown_______	Date of first dose:	Location of first dose:	Received last year? ___yes ___no

Gestational Age: ______ 28 wks, 6 days ______ 29 wks, 0 days to 31 wks, 6 days _______ 32 wks, 0 days to 34 wks, 6 days

ICD Code: ______ 765.10 Premature _____Other:

Please check the one criteria that best applies to this patient: (One of the following criteria must be checked)

1	<24 months old (as of November 15) and with **hemodynamically significant congenital heart disease (CHD)** specify type:			
2	<24 months old (as of November 15) and with **chronic lung disease (CLD) of prematurity** requiring oxygen or pulmonary medication in the last six months (specify below)			
3	<24 months old (as of November 15) and with **Severe Immunodeficiency** (specify type)			
4	<12 months old (as of November 15) and born at 34 wks,6 days gestation or less and **Severe Neuromuscular Disease with inability to clear secretions**			
5	<12 months old (as of November 15) and born at 34 wks,6 days gestation or less and **Congenital Abnormality of the Airway with inability to clear secretions**			
6	<12 months old (as of November 15) and born at **28 wks, 6 days gestation** or less			
7	<6 months old (as of November 15) and born **29 wks, 0 days to 31 wks, 6 days gestation**			
8	<90 days of age (as of November 15) and born at **32 wks, 0 days to 34 wks, 6 days gestation** *and with 1 or more risk factors:*			
8a	Childcare attendance	Date Starting:	Name of Childcare:	Phone:
8b	Sibling(s) in home under 5 years		Ages:	

Please list any other pertinent information, including medical records that document CLD or CHD in 32 to 35 weeks gestation, other risk factors, and specialists involved in the care of this patient.

STATEMENT OF MEDICAL NECESSITY

I hereby certify that the above services are medically necessary and are authorized by me. This patient is under my care and is in need of the services listed.

Molina/BCBS/Presbyterian Prescription Information

☐ Administer Synagis (Palivizumab) 15 mg/kg IM every month (q28-31 days) for duration of RSV season as determined by the patient's health insurance plan. Epinephrine 1:10,000; 0.01mg/kg for anaphylaxis as directed. Upon parent's choice of agency, home nursing to be arranged by member's health insurance agency.

Provider Signature: **X** **Date:**

Lovelace Prescription Information

☐ Administer Synagis (Palivizumab) 15 mg/kg IM every month (q28-31 days) for duration of RSV season as determined by the patient's health insurance plan. Epinephrine 1:10,000; 0.01mg/kg for anaphylaxis as directed.

☐ Deliver Synagis (Palivizumab) to provider's office for administration as above. Refill x ___

Provider Signature: **X** **Date:**

INDIVIDUAL ORDERS:

☐ Administer Synagis (Palivizumab 15 mg/kg IM every month (q28-31 days) for duration of RSV season as determined by patient's health insurance plan.

☐ Epinephrine 1:10,000; 0.01mg/kg IM for anaphylaxis as directed

☐ Deliver Synagis (Palivizumab) to provider's office for administration as above.

☐ Arrange home health care agency to administer Synagis (Palivizumab).

Provider Signature: **X** **Date:**

APPROVED: Authorization#	**Authorization by:**	**Date:**
DENIED:		

Presbyterian	Fax: 505-923-5540 or 800-724-6953	BCBSNM/Blue Salud	Fax: 505-816-3853
Lovelace Health Plan	Fax: 505-727-5390	United Health Care	Fax: 800-441-4036 (Pharmacare)
Molina Healthcare of New Mexico	Fax: 866-472-4578		