



SYNAGIS® PRIOR AUTHORIZATION PHYSICIAN FAX FORM

PLEASE USE THIS FORM IF YOUR PRACTICE PURCHASES SYNAGIS AND BILLS BCBSKS Only the prescriber may complete this form.

The following documentation is REQUIRED for prior authorization. Incomplete forms will be returned for additional information. For formulary information, please visit the Blue Cross and Blue Shield of Kansas Web site at www.bcbsks.com.

PATIENT INFORMATION

Today's Date: _____

Form with fields for Patient Name (First/Last), M, DOB, Patient Address, City, State, Zip, and Patient Telephone.

INSURANCE INFORMATION

Form with fields for Insurance ID Number and Group Number.

PHYSICIAN/CLINIC INFORMATION

Form with fields for Prescriber Name, Physician UPIN#, Physician NPI#, Specialty, Contact Name, Clinic Name, Clinic Address, City, State, Zip, Phone #, and Secure Fax #.

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Form with fields for Patient's Primary Diagnosis, Gestational Age, Birth Weight, Current Weight, Date Recorded, and checkboxes for various medical conditions.

MEDICAL CRITERIA:

- 1. Diagnosis of chronic pulmonary disease (CLD/BPD) and less than 24 months of age?
2. Diagnosis of hemodynamically significant congenital heart disease (CHD) and less than 24 months of age?
3. Clinically has the following risk factors (Check all that apply)
4. Is this the first dose? Yes No

Please fax or mail this form to:

Prime Therapeutics LLC
Clinical Review Department
1020 Discovery Road, No. 100
Eagan, Minnesota 55121

TOLL FREE

Fax: 877.480.8130 Phone: 866.469.5660

CONFIDENTIALITY NOTICE:

This communication is intended only for the use of the individual entity to which it is addressed, and may contain information that is privileged or confidential.

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