



**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: _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip	Patient Telephone:	

INSURANCE INFORMATION

Insurance ID Number:	Group Number:
----------------------	---------------

PHYSICIAN/CLINIC INFORMATION

Prescriber Name:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

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

Patient's Chronological Age (Months): _____	Birth Weight: ____ kg or ____ lb
Current Weight: ____ kg or ____ lb	Date Recorded: _____

GESTATIONAL AGE:

- ≤ 28 weeks, 6 days
- ≥ 32 weeks, 0 days through 34 weeks, 6 days
- 29 weeks, 0 days through 31 weeks, 6 days
- ≥ 35 weeks, 0 days

MEDICAL CRITERIA:

- Diagnosis of chronic pulmonary disease (CLD/BPD) and less than 24 months of age?
Is patient receiving medical treatment of (check all that apply and provide last date received): Oxygen Date: _____
 Corticosteroids Date: _____ Bronchodilator Date: _____ Diuretics Date: _____
- Diagnosis of hemodynamically significant congenital heart disease (CHD) and less than 24 months of age?
Indicate which of the following apply:
 Medications to control CHF: _____ Last date received: _____
 Diagnosis of moderate-severe pulmonary hypertension Cyanotic CHD
 Cardiopulmonary bypass surgery during current RSV season
- Other Medical Conditions:**
 Severe combined immunodeficiency or advanced acquired immunodeficiency & < 24 months of age
 Congenital abnormalities of the airway or neuromuscular condition that compromises handling of respiratory tract secretions & < 12 months of age
- Clinically has the following risk factors (Check all that apply)
 Siblings or other children < 5 years of age living permanently in the same household
 Daycare attendance (home or facility)
- Is this the first dose? Yes No If no, date first dose given: _____
 Start ASAP Date next dose due: _____
 Was Synagis administered in NICU/Hospital? If yes, date first dose given: _____

Please fax or mail this form to:

Prime Therapeutics LLC
Clinical Review Department
1305 Corporate Center Drive
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. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone at 866.469.5660, and return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.

Blue Cross and Blue Shield of Kansas is an independent licensee of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. Prime Therapeutics LLC is an independent limited liability company providing pharmacy benefit management services.