

**SYNAGIS®**  
(palivizumab)

**SYNAGIS Medical Exception  
Worksheet/Prescription Order Form.**  
Please FAX this completed form to:  
**Fax: (866) 940-7328 Phone: (800) 310-6826**



**PATIENT INFORMATION (BOLD ITEMS ARE REQUIRED)**

**Patient's (Child's) Name:** \_\_\_\_\_  M  F **Patient's SS#:** \_\_\_\_\_ **DOB:** \_\_\_\_\_  
**Gestational Age (GA)** \_\_\_\_\_ **Weeks**      **Days**      **Birth Weight** \_\_\_\_\_ **lb/kg**      **Current Weight** \_\_\_\_\_ **lb/kg**      **Date:** \_\_\_\_\_  
**Patient's Address:** \_\_\_\_\_ **Daytime Phone:** ( ) \_\_\_\_\_  
**City/State/Zip:** \_\_\_\_\_ **Evening Phone:** ( ) \_\_\_\_\_  
**Parent's Name:** \_\_\_\_\_ **Cell Phone:** ( ) \_\_\_\_\_ **Best Time to Call:** \_\_\_\_\_  
**Member I.D. Number:** \_\_\_\_\_ **Other Insurance:** \_\_\_\_\_

**MEDICAL AUTHORIZATION CLINICAL CRITERIA (Please check ALL that apply.)**

<b>Infant/Child's Condition</b>	
<input type="checkbox"/>	≤ 28 6/7 weeks GA, (< 12 months of age at start of RSV season)
<input type="checkbox"/>	29 0/7 – 31 6/7 weeks GA, (< 6 months of age at start of season)
<input type="checkbox"/>	32 0/7 - 34 6/7 weeks GA (<3 months of age at start of RSV season); check all risk factors that apply.
<input type="checkbox"/>	Other - Explain: _____
<b>Risk Factors Consideration</b>	<b>Diagnosis for Consideration (Please Check ALL that apply.)</b>
<input type="checkbox"/> Siblings < 5 years of age	<input type="checkbox"/> Immunosuppressive/autoimmune disease <input type="checkbox"/> Other
<input type="checkbox"/> On O <sub>2</sub> /Airway Support	<input type="checkbox"/> Severe Neuromuscular Disease <b>Please note:</b>
<input type="checkbox"/> Child Care Attendance	<input type="checkbox"/> Congenital Abnormalities of Airways <b>Risk Factors for Consideration are subject to clinical and medical review</b>
Day Care Name/Ph#: _____	
<input type="checkbox"/> 770.7 (Please document Neonatal Treatment) →	<b>Chronic Lung Disease/BPD: Infants and children ≤ 24 months</b> with Chronic Lung Disease (CLD) who have received treatment for the medical condition in the 6 months prior to RSV season. <b>Neonatal Treatment:</b> Mechanical ventilation:    yes / no      Days/Duration _____ Supplemental oxygen:    yes / no      Days/Duration _____ Steroids and/or diuretics:    yes / no      Days/Duration _____ Other                            yes / no      Days/Duration _____ <b>Recent therapy for Chronic Lung Disease (Therapy and Dates):</b> _____
<input type="checkbox"/> _____ (745-747)	<b>Cardiac (CHD) – Hemodynamically Significant</b> Infant is ≤24 months with hemodynamically significant cyanotic & acyanotic CHD Comments: _____

**PRESCRIBER INFORMATION (REQUIRED)**

**Prescriber's Name:** \_\_\_\_\_ **State License #** \_\_\_\_\_ **DEA#** \_\_\_\_\_  
**Practice Name:** \_\_\_\_\_ **NPI:** \_\_\_\_\_  
**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_  
**Phone** \_\_\_\_\_ **Fax:** \_\_\_\_\_ **Synagis Contact:** \_\_\_\_\_

**RX INFORMATION      SPECIAL INSTRUCTIONS:** \_\_\_\_\_

**Synagis® (palivizumab) 50 mg and/or 100 mg vials      Sig:** Inject 15 mg/kg IM one time per month      **# Doses** \_\_\_\_\_  
**Date for first Injection:** \_\_\_\_\_ **Delivery to:**  MD Office       Patient's Home  
**Prescriber's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for return of these documents.

*Thank you. Please FAX this completed form to:*  
**Fax: (866) 940-7328.**