


<b>Unison Health Plan</b> <b>SYNAGIS®</b> (palivizumab)	<b>SYNAGIS Medical Exception</b> <b>Worksheet/Prescription Order Form.</b> Please FAX this completed form to <b>Unison Health Plan</b> Pharmacy Department at: <b>Fax: (412) 457-1328 or (866) 639-7785</b>	
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**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	<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.
(Please document Neonatal Treatment) →	<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:** \_\_\_\_\_

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*Thank you. Please FAX this completed form to Unison Health Plan*  
**Fax: (412) 457-1328/(866) 639-7785 or Ph: (412) 380-6015/(877) 651-2217.**