

New Mexico Synagis Prior Authorization / Statement of Medical Necessity / Order Form

Valid 2017-2018

BCBS Presbyterian Molina UnitedHealthcare Lovelace 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:		Office Contact 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: _____ **less than or equal to 28 weeks, 6 days OR other criteria met				

Circle the one criterion that best applies to this patient: (One of the following must be circled and must provide supporting documentation)		ICD 10 Code:
1	<12 months old (as of November 15) and with hemodynamically significant congenital heart disease (CHD)	
2	a. <12 months old (as of November 15), < 32wks 0 days with chronic lung disease (CLD) of prematurity requiring oxygen of FiO2 >21% for >28 days after birth	
	b. <24 months with chronic lung disease (CLD) and continues on supplemental oxygen, diuretic or corticosteroid	
3	<24 months old (as of November 15) and with Severe Immunodeficiency (specify type)	
4	<12 months old (as of November 15) with Severe Neuromuscular Disease with inability to clear secretions	
5	<12 months old (as of November 15) with 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	<24 months old (as of November 15) and who undergo cardiac transplantation during the RSV season	

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 / UnitedHealthcare Prescription Information

- Administer Synagis (Palivizumab 15mg/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; 0.01 mg/kg for anaphylaxis as directed.
- Arrange home health care agency to administer Synagis (Palivizumab)

Provider Signature: X

Date:

INDIVIDUAL ORDERS:

- Administer Synagis (Palivizumab 15mg/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; 0.01 mg/kg for anaphylaxis as directed.
- Arrange home health care agency to administer Synagis (Palivizumab)

Provider Signature: X

Date:

APPROVED: Authorization #	Authorization by:
DENIED:	

Presbyterian Fax: 505-923-5540 or 800-724-6953

BCBS New Mexico Fax: 505-816-3853

Molina Healthcare of New Mexico Fax: 866-472-4578

UnitedHealthcare Fax: 866-940-7328