BOSTON MEDICAL CENTER HEALTHNet PLAN

WELL SENSE HEALTH PLAN

MASSACHUSETTS STANDARD FORM FOR SYNAGIS®

PRIOR AUTHORIZATION REQUESTS

Version 1.0 Effective: 12/11/2017

Phone: 888-566-0008 Fax back to: 866-741-8136

**Some plans might not accept this form for Medicare or Medicaid requests.*

A. Destination	
Health Plan or Prescription Plan Name:	
Health Plan Phone:	Health Plan Fax:

B. Patient Information		
Patient Name:	DOB:	Gender: ☐ Male ☐ Female ☐ Other: _____
Member ID #:		

C. Prescriber Information	
Prescribing Clinician:	Phone #:
Specialty:	Secure Fax #:
NPI #:	DEA #:
Prescriber Point of Contact Name (POC) (if different than prescriber):	
POC Phone #:	POC Secure Fax #:
POC Email (not required):	
Prescribing Clinician or Authorized Representative Signature:	
Date:	

D. Medication Information		
Check if Expedited Review/Urgent Request: ☐ (In checking this box, I attest to the fact that this request meets the definition and criteria for expedited review and is an urgent request.)		
Is the patient currently being treated with the drug requested? ☐ Yes ☐ No		
If yes, date started:	Date of last dose received:	Number of doses received:
Number of doses requested:		

E. Patient Clinical Information		
Primary Diagnosis Related to Medication Request: ICD Code(s):		
Gestational age: # weeks:	#days:	
Birth weight:	Current weight:	Date current weight recorded:
Pertinent Concurrent Medications:		
Allergies:		

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Clinical Conditions {2014 AAP Committee on Infectious Disease and Bronchiolitis Guidelines)	
Chronic lung Disease (CID)	CLD of prematurity defined as gestational age ≤31 weeks, 6 days, AND requirement for 21% oxygen for at least the first 28 days after birth ☐ <12 months of age with CLD ☐ 12-24 months of age with CLD AND continues to require medical support during the 6-month period before second RSV season AND ☐ Supplemental oxygen (dates):_____ ☐ Diuretic therapy (drugs/dates):_____ ☐ Chronic corticosteroids (drugs/dates):_____ ☐ 0ther_____ **Chronic Respiratory Disease arising in the perinatal period:** ☐ Wilson-Mikity Syndrome (P27.0) ☐ Bronchopulmonary Dysplasia originating in the perinatal period (P27.1) ☐ Other chronic respiratory disease originating in the perinatal period (P27.8) **Congenital Abnormality of the Lungs:** _____ _____
Congenital Heart Disease (CHD)	☐ <12 months of age at start of season with ~~hemod~~ynamically significant CHD such as: ☐ Acyanotic heart disease and rece~~iving med~~ication to control congestive heart failure and surgery to correct (drugs/dates):_____ (surgery date):_____ ☐ Moderate to severe pulmonary hypertension ☐ Other (describe):_____ ☐ 12-24 months of age undergoing cardiac transplant during RSV season (date of planned surgery):_____ ☐ Cyanotic Heart Disease------Diagnosis:_____
Airway/Neuromuscular Conditions	☐ <12 months of age at start if season and compromised handling of secretions AND due to: ☐ Significant abnormality of the airway (attach clinical notes) ☐ Neuromuscular condition (attach clinical notes)
Prematurity	☐ ≤ GA 28 weeks, 6 days AND <12 months at start of season
Other medical conditions or history	☐ Cystic Fibrosis ☐ Down's Syndrome ☐ Immunocompromised ☐ Describe other relevant medical history: _____ _____ _____ _____

Complete this section for Professionally Administered Medications {including Buy and Bill}	
Start Date:	End Date:
Servicing Prescriber/Facility Name:	☐ Same as Prescribing Clinician
Servicing Prescriber/Facility Address:	
Servicing Provider NPI/TAX ID#:	
Name of billing provider:	
Billing Provider NPI#	
Is this a request for reauthorization? ☐Yes ☐No	
CPT Code:_____ # of Visits:_____ J Code: _____ # of Units:_____	

Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form.
Providers may attach any additional data relevant to medical necessity criteria.