SYNAGIS (PALIVIZUMAB)

Request Form

FAX to 503-416-8109

(Revised on 01/24/2018)

CareOregon
315 SW Fifth Avenue, Suite 900
Portland, Oregon 97204
503-416-4100 or 800-224-4840
800-735-2900 (TTY/TDD)
www.careoregon.org

For assistance with this form, you may call CareOregon at 503.416.4100 or 800.224.4840 - Monday through Friday from 8 am - 5 pm. CareOregon requests careful selection when checking urgent as it delays review of other requests that may seriously jeopardize the health of another member, please mark URGENT only as necessary.

**** Please complete all fields legibly and we recommend providing supporting medical records ****

CareOregon reviews all requests within 24 hours.

☐ Urgent Request: By selecting the expedited review and signing this form below, I certify that applying the standard review will seriously jeopardize the life or health of the member. **Both Standard and Urgent requests will be reviewed within 24 hours.**

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name and Specialty:	
Member ID#:		NPI#:	
Gender: ☐ Male ☐ Female		Prescriber Office Phone:	Prescriber Office Fax:
Date Of Birth:	Current Weight (kg):	Prescriber Contact Person:	
Drug: SYNAGIS	**Directions:** Inject 15 mg/kg IM one time per month	**# Doses Requested:**	

Please complete the following and attach supporting medical records:

☐ Gestational age at birth: _____ weeks, _____ days

- Note- AAP 2014 guidelines recommend routine prophylaxis for gestational age less than 29 weeks, 0 days who are younger than 12 months of age **OR** one of the following:

☐ Younger than 24 months with chronic lung disease of prematurity meeting the following (please check all that apply)

☐ Less than 32 weeks, 0 days gestational age; **AND**

☐ >21% oxygen needed for at least 28 days after birth

AND for ages 12-24 months continued medical need for:

☐ supplemental oxygen **OR** ☐ chronic corticosteroids **OR** ☐ diuretic therapy

☐ Younger than 12 months with hemodynamically significant congenital heart disease. ICD-10; _____ **AND**

☐ Moderate to severe pulmonary hypertension; **OR**

☐ Acyanotic congenital heart disease **AND** receiving medication to control CHF, AND will require cardiac surgical procedures

- Please list current medication

Other Pertinent History (including congenital abnormalities of the airway or immunocompromised status):

_____

_____

_____

Please note: For the 2017-2018 Synagis Season, this medication will be provided by Briova Rx Specialty Pharmacy (phone: 866-235-3193, fax: 866-391-1890). Once your request is approved you may initiate the referral form process with BriovaRx using a) their entire referral form or b) this PA form AND the additional risk factors section of the BriovaRx Referral form.

Physician's Signature: _____ **Date:** _____