Synagis (PALIVIZUMAB) Medication Request Form

Fax Form to 503-416-8109

CareOregon

For assistance with the 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

Patient Name: _____ Member ID# _____

Patient DOB: _____ Pharmacy Name: _____

Pharmacy Phone: _____ Gender: ☐ Male ☐ Female Current Weight (kg): _____

Prescriber Information

Prescriber Name: _____ NPI# _____

Clinic Name: _____ Prescriber Office Phone: _____ Prescriber Office Fax: _____

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 2021-2022 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)** BriovaRx Referral Form or **b)** This PA Form **AND** the additional risk factors section of the BriovaRx Referral Form.

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