WellCare Health Plans

Georgia Families® Choices for a Healthy Life | PeachCare for Kids®

SYNAGIS® PRIOR AUTHORIZATION REQUEST FORM FOR RESPIRATORY SYNCYTIAL VIRUS (RSV)

Instructions: Please complete ALL FIELDS and FAX COMPLETED FORM TO 1-866-455-6558.

Visit our website for Prior Authorization criteria at www.wellcare.com.

Member Name:		Prescriber FULL Name/Specialty:
Member ID #:	Date of Birth:	Prescriber NPI:
Member's Telephone Number:		Office Address:
Diagnosis for use of the requested medication(s):		
Patient's Birth Weight:	Patient Current Weight (kg):	Contact Name at MD Office:
Patient's Gestational Age: Weeks______Days______		Office Phone #:
Was the member part of a multiple birth? ☐ Yes ☐ No		Office Fax #:
DRUG REQUESTED (include strength and dosage form):		
Quantity:	**Expected date of first/next injection:**	
Received previous injections this season? ☐ Yes ☐ No If Yes, date:		

****REQUIRED DOCUMENTATION – Please submit all required clinical notes/lab reports in reference to this request.****

1. **Diagnosis of chronic pulmonary disease (CLD/BPD) and less than 24 months of age at start of RSV season?**
   ☐ Yes ☐ No ICD-9 (REQUIRED) _______________
   Is patient receiving medical treatment of (only required for second year of life)? (Check all that apply and provide last date received):
   ☐ Oxygen Date ___________ ☐ Corticosteroids Date ___________
   ☐ Diuretics Date ___________
   Did the patient receive oxygen for at least the first 28 days after birth? ☐ Yes ☐ No _____% Oxygen (REQUIRED)
2. **Diagnosis of hemodynamically significant congenital heart disease and less than 12 months of age at start of RSV season?** ☐ Yes ☐ No ICD-9 (REQUIRED) _______________
   Patient HAS the following conditions:
   ☐ Diagnosis of moderate-severe ☐ Pulmonary hypertension
   ☐ Cyanotic heart disease ☐ Acyanotic heart disease
   ☐ Medications for CHF _________________________ Last Received: ___________
3. **Prematurity**
   ☐ Gestational age of < 29 Weeks & ≤ 12 months at the start of RSV season
   ☐ Other ____

Other Medical History:

By signing below, you attest that all statements on this form as true to the best of your knowledge.

Prescriber's Signature____**Date**______________________________

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