

# Universal Synagis Authorization Form

\*Fax the COMPLETED form or call the plan with the requested information.

<b>Absolute Total Care</b> P: 866-433-6041 F: 855-865-9469	<b>FFS Medicaid</b> P: 866-247-1181 F: 888-603-7696	<b>First Choice</b> P: 866-610-2773 F: 866-610-2775	<b>Healthy Blue by BlueChoice</b> P: 866-902-1689 F: 800-823-5520	<b>Molina Healthcare</b> P: 855-237-6178 F: 855-571-3011	<b>WellCare</b> P: 888-588-9842 F: 866-354-8709
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If the following information is not complete, correct, or legible, the PA process can be delayed. Use one form per member please.

### Member Information

**LAST NAME:**

**FIRST NAME:**

**MEDICAID ID NUMBER:**

**DATE OF BIRTH:**

 -  - 

### Prescriber Information

**LAST NAME:**

**FIRST NAME:**

**NPI NUMBER:**

**DEA NUMBER:**

**PHONE NUMBER:**

 -  - 

**FAX NUMBER:**

 -  - 

**STRENGTH:**

 50 mg (NDC 60574411401)  
 100 mg (NDC 60574411301)

**QUANTITY:**

**QUANTITY**

**PA START DATE**

**PA START DATE**

**NAME OF DISPENSING PHARMACY:**

**NPI NUMBER:**

**PHONE NUMBER:**

 -  - 

**FAX NUMBER:**

 -  - 

### Clinical Criteria Documentation

\*\*\*\*Do not include documentation that is not requested on this form\*\*\*\*

1. What was the patient's gestational age at birth, current weight, and gender?

\_\_\_\_\_ weeks                      \_\_\_\_\_ days  
 \_\_\_\_\_ kg                      or                      \_\_\_\_\_ lb

Male                       Female

3. Does the patient have Chronic Lung Disease of Prematurity (Formerly called bronchopulmonary dysplasia)  Yes (go to question 3)  No

4. Did the patient receive oxygen immediately following birth?  Yes (go to question 4)  No (go to question 6)

5. Please indicate the % oxygen received, date received, and the duration of treatment:

6. Please indicate if patient is receiving any of the following respiratory support therapies on a daily basis:

<input type="checkbox"/> Oxygen	Most recent date	_____
<input type="checkbox"/> Systemic corticosteroids	Most recent date	_____
<input type="checkbox"/> Diuretics	Most recent date	_____
<input type="checkbox"/> Bronchodilator	Most recent date	_____

7. Does the patient have a diagnosis of Cystic Fibrosis?  Yes (submit documentation of pulmonary & nutritional status)  No

8. Please indicate if patient has any of the following:

Anatomic Pulmonary Abnormality, specify: \_\_\_\_\_  Neuromuscular Disorder, specify: \_\_\_\_\_  
 Congenital anomaly that impairs the ability to clear secretions, specify: \_\_\_\_\_

