BlueCross BlueShield Federal Employee Program

SYNAGIS
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Synagis (palivizumab)

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. Is Synagis being used to prevent infection caused by Respiratory Syncytial virus (RSV)? ❒Yes ❒No
2. Will the 1st dose be administered 1 month prior to or during the RSV season*? ❒Yes ❒No
   RSV season starts November 1st each year. The first dosage could be administered as early as October 1st
3. What will the patient's age be (in months) at the start of dosing? _____ months
4. What was the patient's gestational age (in weeks) at birth? _____ weeks
5. Please select any of the following diagnoses which apply to the patient:
   - ❒ Chronic lung disease (CLD)
     a. Does the CLD require continued medical support? ❒Yes ❒No
   - ❒ Hemodynamically significant congenital heart disease (e.g. congestive heart failure or pulmonary hypertension)
   - ❒ Congenital airway abnormality that impairs the ability to clear secretions
   - ❒ Neuromuscular disorder that decreases the ability to manage airway secretions
   - ❒ Other ***(please specify):*** _____
6. Is the patient a cardiac transplant or bypass patient? ❒Yes ❒No
7. Is the patient severely immunocompromised? ❒Yes ❒No

RSV season will be determined by the CDC National Respiratory and Enteric Virus Surveillance System

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug prior authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same info contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727** Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the PA request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***