Harvard Pilgrim Health Care

SYNAGIS® (palivizumab)

Medication Request Form (MRF)
FAX TO: (800) 323-2445
c/o CVS Specialty Pharmacy

For drug delivery questions call 1-800-237-2767

Instructions:
This form is to be used by participating providers to obtain coverage for the drugs listed in the top right corner, which require prior authorization. Please complete this form and fax it to CVS Specialty Pharmacy at (800) 323-2445.
Questions about the clinical criteria used to make this determination may be discussed by contacting the HPHC Clinical Pharmacy Services Department at (617) 509-1786.

***** ONLY COMPLETED FORMS CAN BE PROCESSED *****

Member Information:

HPHC Member's Name:
HPHC Member's HPHC ID #:
HPHC Member's DOB (mm-dd-yy)**:**
Parent/Guardian Name:
Parent/Guardian Telephone Number:

Provider Information:

Prescriber's Name:
Prescriber's Specialty:
HPHC Affiliated Physician? YES ☐ NO ☐
Prescriber's Office Address
City, State, Zip
Provider's Telephone Number/Contact Name:
Provider's (Area Code) Fax Number:

PRIMARY DIAGNOSIS: _____

GESTATIONAL AGE: _____ weeks _____ days

CURRENT WEIGHT: _____ lbs _____ oz = _____ kg **DATE:** _____

Months requesting Synagis to be administered: ☐ Nov ☐ Dec ☐ Jan ☐ Feb ☐ March

MEDICAL CRITERIA (Please check appropriate boxes in ONE row only):

Gestational age	Chronological age as of 11/1/2017	Check all that apply:
☐ All ages	☐ < 24 months	☐ Hemodynamically significant cyanotic or acyanotic congenital heart disease (including moderate to severe pulmonary hypertension or on medications to control congestive heart failure) ☐ Chronic lung disease and has received treatment after 5/1/15 [if checked please indicate treatment(s)/medication(s) below] ☐ Supplemental O2 therapy ☐ Bronchodilator: _____ ☐ Diuretic: _____ ☐ Chronic corticosteroid: _____ ☐ Other: _____
☐ All ages	☐ < 12 months	☐ Congenital abnormalities of the airways ☐ Neuromuscular disease that compromises handling of respiratory tract secretions
☐ ≤ 28 weeks, 6 days	☐ < 12 months	☐ 1st RSV Season
☐ 29 weeks, 0 days to 31 weeks, 6 days	☐ < 6 months	
☐ 32 weeks, 0 days to 34 weeks, 6 days	☐ < 3 months	☐ Attends child care or daycare ☐ Sibling younger than 5 years of age living permanently in the home (**NOT** including multiple births < 1 year of age)

Rx **PRESCRIPTION** **Rx**

DRUG: ☐ Synagis 50mg or ☐ Synagis 100mg | Dispense Quantity: QS

Sig: Inject 15mg/kg IM once/month | Refills:_____ **PLEASE NOTE: Max of 5 doses per season.**

Physician Name (Print): _____

NPI #: _____ DEA #: _____

Deliver product to: ☐ Office ☐ Alternate address below (circle): Patient's home Clinic

Alternate shipping address: _____ Suite/Apt: _____

City: _____ State: _____ Zip:_____

Contact: _____

Phone #: _____ Fax #: _____

Physician Signature: _____Date:_____

Interchange is mandated unless the practitioner writes the words "no substitution" in this space: