## SYNAGIS (PAVILIZUMAB) PRIOR AUTHORIZATION FORM





(form effective 1/5/21)

Fax to PerformRx<sup>SM</sup> at **1-855-851-4058**, or to speak to a representative call **1-866-907-7088**.

PRIOR AUTH	HORIZATIO	N REQUES	T INFORMATI	ON							
☐ New request ☐ Renewal request # of pages:				Name of office contact:							
Contact's phone number:				LTC facility contact/phone:							
PATIENT INF	FORMATIO	N									
Patient name:						Patient ID #	:		DOB:		
Street address:					Apt. #:	#: City/state/zip:					
PRESCRIBE	R INFORM	NOITA									
Prescriber name:					Specialty:						
State license #: NPI:			NPI:				MA Provider ID #				
Street address:				Suite #: City/		City/stat	tate/zip:				
Phone:						Fax:					
CLINICAL IN	IFORMATIC	N									
Chronological age:						Gestational age: weeks days					
-	Current weight: lbs oz. OR kg						Total number of doses requested (maximum of 5 monthly doses): months				
Synagis dose: 15	mg/kg/dose X (	weight in kg)	kg =	m	g per d	ose					
PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):  Deliver to:  Patient's Home  Physician's Office  Patient's Preferred Pharmacy Name:  Pharmacy Phone #: Pharmacy Fax #:  I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.											
				oi uciiveiy o	บ แมร ม	redication.					
Check which	n criteria ap	ply and subr	,				each iter	<b>n.</b> (Pennsylvania R	SV season begins N	lovember 1):	
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