CIGNA®

Pharmacy Services

Phone: (800)244-6224
Fax: (800)390-9745

CIGNA HealthCare Prior Authorization Form
- Synagis (Palivizumab) -

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

PROVIDER INFORMATION			PATIENT INFORMATION	
* Provider Name:			**Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed**	
Specialty:				
* DEA or TIN:			* Patient Name:	
Office Contact Person:			* CIGNA ID:	
Office Phone:			* Date Of Birth:	
Office Fax:			* Patient Street Address:	
* Is your fax machine kept in a secure location? Yes ☐ No ☐ * May we fax our response to your office? Yes ☐ No ☐			City	
Office Street Address:			State	Zip
City	State	Zip	Patient Phone Number:	

Medication requested:

☐ SYNAGIS (palivizumab) 50mg vial ☐ SYNAGIS (palivizumab) 100mg vial
☐ Other (*please specify*):

Dose and Quantity: No. of Doses: J-Code:

Where will this medication be obtained?

☐ CIGNA Tel-Drug *(CIGNA's nationally preferred specialty pharmacy)* ☐ Retail pharmacy
☐ Prescriber's office stock (billing on a medical claim form) ☐ Home Health / Home Infusion vendor
☐ Other (please specify):

Clinical Data:

Infant / child's Weight: Date recorded:

Please provide anticipated month of start of RSV season in patient's residence area:

What is the ZIP code of the infant's residence if different than above:

Please specify the number of injections you are requesting:

☐ 3 injections
☐ 5 injections
☐ other:

What is the start date of therapy? What is the end date of therapy?

Please note: *If you are requesting administration prior to September 1, 2010, please provide justification necessitating early administration and include supporting data from the CDC or local health department supporting an early start date to Synagis season.*

Does the patient have any of the following conditions? (Please check all that apply to this patient):

☐ Prematurity
☐ Chronic Lung Disease
☐ Congenital Heart Disease
☐ Congenital Abnormalities of the Airway or Neuromuscular disease
☐ Severe Immunodeficiency

For patients with Chronic Lung Disease:
Has this patient required any of the following medical care for their Chronic Lung Disease within the last 6 months?
(Please check all that apply to this patient):

- ☐ Supplemental oxygen Date of last use
- ☐ Treatment with a bronchodilator date of last use
- ☐ Treatment with a diuretic date of last use
- ☐ Treatment with a corticosteroid date of last use

For patients with Congenital Heart Disease:
Does this patient have hemodynamically significant heart disease? ☐ Yes ☐ No
Do any of the following conditions apply to this patient? (Please check all that apply to this patient):

- ☐ Receiving medication to control Congestive Heart Failure
- ☐ Have moderate to severe Pulmonary Hypertension
- ☐ Have Cyanotic Congenital Heart Disease

Congenital Abnormalities of the Airway or Neuromuscular disease
Was the infant or child born before 35 weeks gestation? ☐ Yes ☐ No
Is there congenital abnormality of the airway? ☐ Yes ☐ No Diagnosis
Is there neuromuscular disease? ☐ Yes ☐ No Diagnosis
Does this condition compromise the handling of respiratory secretions? ☐ Yes ☐ No

For Prematurity:
What was the patient's gestational age at birth in weeks and days? (Please check the gestational age that applies to this patient):

- ☐ 28 weeks or less
- ☐ Between 29 weeks and 32 weeks 0 days
- ☐ Between 32 weeks 1 day and 34 weeks 6 days
- ☐ 35 weeks or more

Does the patient have any of the following risk factors? (Please check all that apply to this patient):

- ☐ Siblings living in their home If yes: what is the age of the sibling(s)?
- ☐ Child-care or day-care attendance

Additional pertinent information:

CIGNA HealthCare's coverage position on this and other medications may be viewed online at:
http://www.cigna.com/customer_care/healthcare_professional/coverage_positions

Please fax completed form to (800)390-9745. Phone requests may be submitted by calling (800)244-6224.

Our standard response time for prescription drug coverage requests is 2-4 business days. If your request is urgent, it is important that you call Pharmacy Services to expedite the request. View our formulary on line at http://www.cigna.com.

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