Security Health Plan[SM]

Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.548.1224 | 715.221.9588
TTY: 711

Synagis®

Prior Authorization Request

Date ____________________________

Member information		
Member name (print)	SMID	Date of birth (month/day/year)

Provider information		
Provider name (print)	Telephone number	Fax number

Place of service: ☐ Ambulatory Surgery Center ☐ Hospital outpatient ☐ Hospital inpatient ☐ Provider's office ☐ Other ____________________

Facility where services will be provided (include address if the provider provides services at more than one practice location)		
Contact person name (print)	Telephone number	Fax number

Procedure information		
Scheduled date of service (month/day/year)	Requested service/procedure	Procedure code(s)
Diagnosis	Diagnosis code(s)	

Answer all of the following questions.

Was Synagis® administered when the child was hospitalized .... ☐ Yes ☐ No

If yes, indicate the date(s) of administration in the space(s) provided.
(No more than five doses will be authorized, inclusive of any hospital-administered doses.)

1. ____________ 2. ____________ 3. ____________ 4. ____________ 5. ____________

What is the current weight of the child (in kilograms) ______________________________

What date was the child weighed (month/day/year) _________ /_________ /_________

What is the calculated dosage of Synagis® (15 milligrams per kilogram of body weight) ________

Clinical information for chronic lung disease:

The child has chronic lung disease of prematurity .... ☐ Yes ☐ No

Did the child require oxygen at greater than 21% for at least the first 28 days after birth..... ☐ Yes ☐ No

Indicate the child's gestational age at delivery: _________ weeks _________ days

Check all therapies below that the child has continuously used over the past 6 months:
☐ Corticosteroid ☐ Diuretic ☐ Supplemental oxygen

Clinical information for congenital heart disease:

The child is younger than 12 months of age at the start of the respiratory syncytial virus (RSV) season and has hemodynamically significant congenital heart disease .... ☐ Yes ☐ No

Clinical information for cardiac transplant:

The child is younger than 24 months of age at the start of the RSV season and is scheduled to undergo a cardiac transplantation during the RSV season .... ☐ Yes ☐ No

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Clinical information for pre-term infants:

The child is younger than 24 months of age at the start of the RSV season and was born before 29 weeks gestation (i.e. 0 days through 28 weeks, 6 days) . . . . ☐ Yes ☐ No

Indicate the child's gestational age at delivery: __________ weeks __________ days

Clinical information for pulmonary abnormalities and neuromuscular disease:

The child is younger than 12 months of age at the start of the RSV season and has a neuromuscular disease or congenital abnormality that impairs the ability to clear secretions from the upper airway because of an ineffective cough. . . . . ☐ Yes ☐ No

If yes, indicate the disease or anomaly ____

Clinical information for immunocompromised children:

The child is younger than 24 months of age at the start of the RSV season and is profoundly immunocompromised due to the following:

- Solid organ transplant . . . . ☐ Yes ☐ No
- Stem cell transplant . . . . ☐ Yes ☐ No
- Receiving chemotherapy . . . . ☐ Yes ☐ No
- Acquired immune deficiency syndrome (AIDS) . . . . ☐ Yes ☐ No
- Other
  (Indicate the cause of the child's immunodeficiency ________________________________). ☐ Yes ☐ No

By signing this form, the provider attests that the above information is accurate and documented in the medical record. Security Health Plan may, at its discretion, request medical records to make a final coverage determination.

____ ____________________

Provider signature Date

Pre-service decisions: Initial review is received and a coverage determination is made within fourteen (14) calendar days of receipt of request. The member and/or provider are notified in writing of a denial decision within fourteen (14) calendar days of receipt of the request.

Urgent pre-service decisions: Initial review is received and a coverage determination is made within seventy-two (72) hours of receipt of request.

Mail or fax form to:	Security Health Plan Health Services Department PO Box 8000 Marshfield, WI 54449-8000 Fax 715.221.6616	**Marshfield Clinic providers route to:** Health Services Department Routing location, SHP

If you have any questions, please contact Provider Assistance Line at 1.800.548.1224.

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