



BlueCross BlueShield
of Texas

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Synagis

Prior Authorization of Benefits (PAB) Form

Complete form in its entirety and fax to:

Prior Authorization of Benefits Center at (800) 357-9577

1. PATIENT INFORMATION

2. PHYSICIAN INFORMATION

Patient Name: _____ Patient ID #: _____ Patient DOB: _____ Date of Rx: _____ Patient Phone #: _____ Patient Email Address: _____	Prescribing Physician: _____ Physician Address: _____ Physician Phone #: _____ Physician Fax #: _____ Physician Specialty: _____ Physician DEA: _____ Physician NPI #: _____ Physician Email Address: _____
-------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

3. MEDICATION

4. STRENGTH

5. DIRECTIONS

6. QUANTITY PER 30 DAYS

Synagis	_____	_____	Specify: _____
---------	-------	-------	----------------

7. DIAGNOSIS: _____

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

Please indicate the patients age at the start of the Respiratory Syncytial Virus (RSV) season: _____

Yes No Was the patient born prematurely?
If yes, please indicate the gestational age of the infant: _____

Yes No Patient has chronic lung disease (CLD) [formerly designated Bronchopulmonary Dysplasi (BPD)]
 Yes No Patient has required medical treatment within six months before the start of RSV season with oxygen, chronic steroids, bronchodilators or diuretics

Yes No Patient has hemodynamically significant (for example, but not limited to, receiving medication for congestive heart failure or moderate to severe pulmonary hypertension) cyanotic or acyanotic congenital heart disease (CHD)

Yes No Patient is under 2 years of age and has significant congenital abnormalities of the airway (for example, tracheal ring) or a neuromuscular condition, either of which compromises the handling of respiratory secretions

Yes No Are there currently any risk factors present? **If yes**, please select any that apply:
 Patient lives with older siblings or other children who are less than 5 years of age (not including twins or triplets of the patient)
 Patient attends group child care
 Other: _____

Yes No Patient is in an approved course of treatment, has undergone cardiopulmonary bypass for surgical procedures, and has documented reduction in serum levels post-bypass
If yes, please indicate the date of the procedure: _____



**BlueCross BlueShield
of Texas**



EXPRESS SCRIPTS®

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Synagis
Prior Authorization of Benefits (PAB) Form
Complete form in its entirety and fax to:
Prior Authorization of Benefits Center at (800) 357-9577

Patient Name: _____

Patient ID#: _____

9. PHYSICIAN SIGNATURE

_____ Prescriber or Authorized Signature	_____ Date
---------------------------------------------	---------------

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.
 Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation.
 If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

