For your convenience and prior auth coordination, please fax to Maxor Specialty at (866) 217-8034

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

1. PATIENT INFORMATION	2. PHYSICIAN INFORMATION
Patient Name: _____	Prescribing Physician: _____
Patient ID #: _____	Physician Address: _____
Patient DOB: _____	Physician Phone #: _____
Date of Rx: _____	Physician Fax #: _____
Patient Phone #: _____	Physician Specialty: _____
Patient Email Address: _____	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: _____

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2012 TXWPA14 10/09/2012

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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.

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TEXAS STAR PROGRAM
Your Health Plan ■ Your Choice

CHIP

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