



**Phone: 800-842-2015 Fax: 877-837-5922**

<b>PATIENT DATA</b>	Last Name	First Name	Policy Number	Date of Birth	Age
<b>REQUESTING PHYSICIAN DATA</b>	Last Name	First Name	Contact Name	Fax Number ( )	
BCBSLA Provider Number	Area of Practice/Specialty		Name of Place of Treatment	Phone Number ( )	
<b>BILLING DATA</b>	Diagnosis Code(s) (ICD-9) 1) 2)		CPT-4/HCPCS Code	Other Codes	

**PATIENT DATA**

**Anticipated Start Date**

**Patient's Age in Months during month of initial Synagis request: Months** \_\_\_\_\_

**Patient's Gestational Age: Weeks** \_\_\_\_\_ **Days** \_\_\_\_\_

**Patient's Weight in kilograms** \_\_\_\_\_ **kg**

**RISK FACTORS (Check if applicable)**

- Attends Childcare regularly
- Siblings in house are less than 5 years of age

**CLINICAL INFORMATION (Check ALL that apply)**

- Yes  No Does the patient have serious Congenital Heart Disease? If yes, please specify \_\_\_\_\_
- Yes  No Is the patient status post surgical procedure requiring cardiopulmonary bypass? If yes, specify \_\_\_\_\_
- Yes  No Does the patient have Chronic Lung Disease? If yes, specify \_\_\_\_\_
- Yes  No Does the patient have congenital abnormalities of airways? If yes, specify \_\_\_\_\_
- Yes  No Does the patient have neuromuscular disease? If yes, specify \_\_\_\_\_
- Yes  No Does the patient have severe immunodeficiency? If yes, specify \_\_\_\_\_
- Yes  No Has the patient required medical therapy for their CLD? If yes, specify type of therapy and treatment start date \_\_\_\_\_
- OTHER \_\_\_\_\_
  
- Yes  No Will patient be receiving drug in the physician's office?  
If no, list name of servicing provider/facility \_\_\_\_\_

**Number of Injections Requested** \_\_\_\_\_ **Date Span Requested (Ex: Oct-March)** \_\_\_\_\_

List any other relevant clinical info if applicable \_\_\_\_\_

**PHYSICIAN SIGNATURE**

**DATE**

\_\_\_\_\_  
**Prescribing Physician**

**Note:** Please note that the authorization is not a guarantee of payment. Payment is subject to the member's eligibility, benefits, and pre-existing condition limitations at the time the services are provided. We recommend you contact BCBSLA at 800-922-8866 to verify benefits. The submitting provider certifies that the information contained herein is true, accurate, and complete and the requested services are medically necessary to the health of the patient.

**Incomplete forms will not be processed**