peach state health plan

Telephone: (800) 514 - 0083 opt 2
Fax: (866) 374 - 1579

Respiratory Syncytial Virus
Prior Authorization Form/ Prescription

Date: _____ Date Medication Required:_____
Ship to: ❍ Physician ❍ Patient's Home ❍ Other _____

Patient Information

Last Name:	First Name:	Middle:	DOB: ____/____/_____
Address:	City:	State:	Zip:
Daytime Phone:	Evening Phone:	Sex: ☐ Male ☐ Female	

Insurance Information (Attach Copies of cards)

Primary Insurance:		Secondary Insurance:	
ID #	Group #	ID #	Group #
City:	State:	City:	State:

Physician Information

Name:	Specialty:	NPI:	
Address:	City:	State:	Zip:
Phone # ( )	Secure Fax #: ( )	Office contact:	

Primary Diagnosis

ICD-10 Code: _____

☐ Congenital Heart Disease ☐ Chronic Respiratory disease arising in the perinatal period ☐ Congenital Abnormality of Respiratory System ☐ Cystic Fibrosis
☐ < 24 weeks of gestation ☐ 24 weeks gestation ☐ 25-26 weeks of gestation ☐ 27-28 weeks of gestation
☐ 29-30 weeks of gestation ☐ 31-32 weeks of gestation ☐ 33-34 weeks of gestation ☐ 35-36 weeks of gestation
☐ 37+ weeks of gestation ☐ Other

Clinical Information ***** Please submit supporting clinical documentation*****

Patient's gestational age (Required): _____weeks _____days Birth Weight: _____ g/kg/lbs Current Weight: _____ g/kg/lbs Date Recorded: _____
Did the patient spend time in the NICU? ☐ Yes ☐ No ***If yes, provide NICU name and attach discharge summary:*** _____
Was this season's first Synagis dose given in the NICU? ☐ Yes ☐ No ***If yes, provide date(s):*** _____ Expected date of first/next injection: _____

Patient Evaluation (Check all that apply and submit clinical documentation):

☐ Hospitalization for RSV infection this season?
☐ Diagnosis of hemodynamically significant Congenital Heart Disease (CHD) and < 12 months of age at start of RSV Season and patient has the following conditions (Check all that apply):
- ☐ Moderate-Severe Pulmonary Hypertension
- ☐ Cyanotic Heart Disease (if consulted with a pediatric cardiologist)
- ☐ Acyanotic heart disease medications to control CHF (list medications): _____ Last Date Received: _____ AND require cardiac surgical procedures

☐ Diagnosis of Chronic Lung Disease* and less than 12 months at start of RSV Season
*CLD is generally defined as: Infants <32 weeks, 0 days with oxygen requirement > 21% for at least the first 28 days of birth. CLD is NOT defined as asthma, croup, recurrent upper respiratory infections, chronic bronchitis, bronchiolitis, or a history of a previous RSV infection
☐ Diagnosis of Chronic Lung Disease* and between 12 to less than 24 months at start of RSV Season and receiving treatment of (check all that apply and provide last date received):
- ☐ Supplemental oxygen, Date:_____
- ☐ Chronic corticosteroid therapy, Date: _____
- ☐ Diuretic therapy, Date: _____

☐ Diagnosis of Cystic Fibrosis and less than 12 months of age at start of RSV season?
- ☐ Clinical evidence of CLD
- ☐ Nutritional compromise: Explain: _____

☐ Diagnosis of Cystic Fibrosis and between 12 to less than 24 months of age at start of RSV season
- ☐ Manifestations of severe lung disease (hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest radiography or CT that persists when stable)
- ☐ Weight for length less than 10th percentile

☐ Diagnosis of condition that impairs the ability to clear secretions from the upper airway because of ineffective cough *AND* less than 12 months at the start of RSV season
- ☐ Congenital anomaly that impairs the ability to clear secretions from the upper airway because of ineffective cough
- ☐ Neuromuscular condition

Please list other medical history and/or risk factors: _____

Home Health Coordination

Please note, separate authorization is required for injection training/home health visit. Call (866) 296-8731 for prior authorization
☐ Specialty Pharmacy to coordinate injection to coordinate injection training/home health nurse visit as necessary. Please list Agency of choice: _____

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Synagis	☐ 50mg ☐ 100mg	**Inject 15 mg/kg IM one time per month**		
Epinephrine	**1:1000 amp**	**Inject 0.01 mg/kg subcutaneously as directed**		

☐ Prescriber has counseled parent/guardian on Synagis therapy and the specialty pharmacy may contact parent/guardian

Physician's Signature _____ **Date:** _____ ☐ DAW