



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

**Respiratory Syncytial Virus
 Prior Authorization Form/ Prescription**

Date: _____	Date Medication Required: _____
Ship to: <input type="radio"/> Physician <input type="radio"/> Patient's Home <input type="radio"/> Other _____	

Patient Information

Last Name:	First Name:	Middle:	DOB: ___/___/___
Address:		City:	State: Zip:
Daytime Phone:	Evening Phone:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> 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-9/ICD-10 Code: _____

<input type="checkbox"/> Congenital Heart Disease	<input type="checkbox"/> Chronic Respiratory disease arising in the perinatal period	<input type="checkbox"/> Congenital Abnormality of Respiratory System	<input type="checkbox"/> Cystic Fibrosis
<input type="checkbox"/> < 24 weeks of gestation	<input type="checkbox"/> 24 weeks gestation	<input type="checkbox"/> 25-26 weeks of gestation	<input type="checkbox"/> 27-28 weeks of gestation
<input type="checkbox"/> 29-30 weeks of gestation	<input type="checkbox"/> 31-32 weeks of gestation	<input type="checkbox"/> 33-34 weeks of gestation	<input type="checkbox"/> 35-36 weeks of gestation
<input type="checkbox"/> 37+ weeks of gestation	<input type="checkbox"/> 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 Utilization Management at 800-704-1483 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	<input type="checkbox"/> 50mg <input type="checkbox"/> 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