2016 RSV SEASON UPDATE

October 28, 2016

Dear Care1st Providers and Staff:

As RSV season approaches, it is important to make arrangements to ensure that children who need Synagis® receive injections. Care1st will work with your office to authorize and obtain Synagis® with no out of pocket cost.

The guidelines for Synagis® administration are included on the *Care1st RSV Prophylaxis Eligibility Assessment Form* (i.e. Care1st Synagis Form) and is attached for your reference. The Care1st Synagis Form will also be used as the prior authorization form. All Synagis® requests require prior authorization. To obtain prior authorization:

- Please complete the Care1st RSV Prophylaxis Eligibility Assessment Form and *fax it to 602.778.8387 with progress notes*. We will review and process your request as quickly as possible.
- Once your request is approved, you may contact the Los Niños Synagis® Program at 602.424.2146 to schedule an appointment.
- The *Care1st Synagis Form* is also available on our website www.care1st.com/az under the Forms section of the Provider drop down menu.

Please contact the *Care1st Pharmacy Department at 602.778.1800 (Options 5, 5)* if you have any questions.

Thank You!

Provider Network Operations
Phone 602.778.1800 or 866.560.4042 (Options in order: 5, 7)
Email PNOaz@care1st.com
Fax 602.778.1875
Visit our website at www.care1st.com/az

RSV PROPHYLAXIS ELIGIBILITY ASSESSMENT FORM

FAX TO: Care1st Pharmacy Dept. 602.778.8387 **QUESTIONS: 602.778.1800 (Options 5,5)**

Incomplete Forms Will Be Returned

PATIENT INFORMATION

Patient Name: ______________________________ Patient AHCCCS #: ______________

Patient DOB: ______________________________ Patient Phone # with Area Code: ______________

PRESCRIBER INFORMATION

Prescriber Name: ______________________________ NPI #: ______________ License #: __________

Phone # w/Area Code: ______________________________ Fax # w/Area Code: ______________________

Address: (Optional) ____
Address/City/State/Zip

I will be supervising the patient's treatment. Required supporting documentation from the patient's medical record is attached.

______________________________ Prescribing Practitioner Signature (Required) ____________ Date

DRUG/CLINICAL INFORMATION

Drug requested: ______________________________ NDC/J Code: ______________

Strength: ______________ Qty. per month: __________ Number of doses requested: __________

Current Weight: ________ kg. Gestational age: ________ Wks: ______ Days: ______ Chronological age: __________

ICD-9 Codes: ____

Check applicable age, condition:

☐ Gestational age < 29 wks, 0 days and chronological age < 12 months old† ☐ Child ≤ 12 months old† with hemodynamically significant cyanotic or acyanotic Congenital Heart Disease* (CHD)	☐ Child ≤ 24 months old† with Chronic Lung Disease* (CLD) of prematurity defined as gestational age less than 32 weeks, 0 days and has received supplemental oxygen >21% for at least the first 28 days after birth and continues to require medical support (chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) within 6 months before the start of the second RSV season
☐ Child ≤ 12 months old† with pulmonary abnormality or neuromuscular disease that impairs the ability to clear secretions from the upper airway because of ineffective cough	☐ Child ≤ 12 months old† with Chronic Lung Disease* (CLD) of prematurity defined as gestational age less than 32 wks, 0 days and requires supplemental oxygen >21% for at least the first 28 days after birth

† Chronological age at start of RSV season.
* Include ICD-9 codes for the indicated disease states. For CLD/CHD, attach supporting documentation (i.e. progress notes, discharge notes, and/or chart notes) as outlined in the criteria for any submitted diagnosis/ICD-9 code.

AND

Is patient currently outpatient with no inpatient stay in the last 2 weeks? ☐ Yes ☐ No If no, indicate discharge date: __________

Was a dose of Synagis* administered while patient was hospitalized? ☐ Yes ☐ No If yes, indicate date dose administered: ______

Medical justification/Reference attached supporting documentation:

____

____

List all Medications (Include medication name, start date, and end date for diagnoses that require acceptable medical therapy):

____

____

Authorization does not guarantee payment. Please verify eligibility prior to rendering service. Payment will not be made for unauthorized services.

A new Prior Authorization request must be submitted for dosage increases.

ALL APPROVED SYNAGIS SERIES ARE DIRECTED TO THE LOS NIÑOS SYNAGIS PROGRAM

10.01.14