2018 RSV SEASON UPDATE

November 19, 2018

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. Synagis season for 2018/2019 is November through March.

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.
- In Maricopa County, once your request is approved, you may contact the Los Niños Synagis® Program at 602.424.2146 to schedule an appointment. For all other counties, once approved, the Synagis injection series may begin.
- The *Care1st Synagis Form* is also available on our website www.care1staz.com under the Forms section of the Provider drop down menu.

Please contact the *Care1st Pharmacy Department at 602.778.1800 or 1.866.560.4042 (Options 5, 5)* if you have any questions.

Thank You!

Care1st Network Management
Phone 602.778.1800/866.560.4042 (Options in order: 5, 7)
Fax 602.778.1875/Email SM_AZ_PNO@care1stAZ.com
Visit our website at www.care1staz.com
Looking for your assigned Provider Network Rep? On our website go to Providers > Provider Rep Contact Info

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.