2019-2020 RSV (Synagis) Immunization

December 6, 2019

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 2019/2020 is November through April.

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, members may receive the immunization through:
  - Coram Health Infusion (4310 E. Cotton Center Blvd., Suite 110, Phoenix, AZ 85040) **OR**
  - In-home Nurse Administration (in conjunction with Coram/CVS Specialty) **OR**
  - Physician office setting, you may obtain Synagis from either:
    - Exactus Pharmacy (1-866-458-9246) OR
    - CVS Specialty Pharmacies (1-800-237-2767 OR 1-866-387-2573)
- Outside Maricopa County: administer Synagis in the office setting, once your request is approved, please contact one of the Specialty Pharmacies below to coordinate delivery:
  - Exactus Pharmacy (1-866-458-9246) OR
  - CVS Specialty Pharmacy (1-800-237-2767 OR 1-866-387-2573)
- The *Care1st RSV (Synagis) Form* is attached and also available on our website www.care1staz.com under the Forms section of the Provider menu.

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

Thanks!

Care1st Network Management
Ph 602.778.1800/866.560.4042 (Options in order: 5, 7)
Fax 602.778.1875/E-mail 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

CARE1ST HEALTH PLAN ARIZONA
A WellCare Company

RSV (SYNAGIS) ELIGIBILITY ASSESSMENT FORM

FAX TO: Care1st Pharmacy Department 602.778.8387

Questions: 602.779.1800 (Option 5,5)

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ Address: _____ City, State, ZIP: _____

Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)

Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone: _____ Alternate Phone: _____ DOB: _____ Gender: ☐ Male ☐ Female

Email: _____ Last Four of SSN: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____

NPI #: _____ DEA #: _____ Group or Hospital: _____

Address: _____ City, State, ZIP: _____

Phone: _____ Fax _____ Contact Person: _____ Contact's Phone: _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

Prescription Card:

Name of Insurer: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____

Medical Insurance:

Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____

Secondary Insurance:

Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Expected date of first injection: _____ Ship to: ☐ Patient ☐ Office ☐ Other: _____

Diagnosis (ICD-10):

Gestational Age:

☐ < 23 wks (P07.21)	☐ 23 wks (P07.22)	☐ 24 wks (P07.23)	☐ 25 wks (P07.24)
☐ 26 wks (P07.25)	☐ 27 wks (P07.26)	☐ 28 wks (P07.31)	☐ 29 wks (P07.32)
☐ 30 wks (P07.33)	☐ 31 wks (P07.34)	☐ 32 wks (P07.35)	☐ 33 wks (P07.36)
☐ 34 wks (P07.37)	☐ 35 wks (P07.38)		

Nursing:

☐ No nursing coordination ☐ Yes, CVS Specialty® to coordinate home health nurse visit for injection

Chronic Respiratory Disease Arising in the Perinatal Period:

☐ Wilson-Mikity Syndrome (P27.0)
☐ Bronchopulmonary Dysplasia originating in the perinatal period (P27.1)
☐ Other chronic respiratory disease originating in the perinatal period (P27.8)

Congenital Abnormality of Respiratory System:

☐ Congentical Subglottic Stenosis (Q31.1)
☐ Laryngocele (Q31.3)
☐ Other Congenital Malformations of Larynx (Q31.8)
☐ Other Congenital Malformations of Trachea (Q32.1)
☐ Other Congenital Malformations of Bronchus (Q32.4)
☐ Congenital Cystic Lung (Q33.0)

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record.

2019-2020 Synagis® Seasonal Respiratory Syncytial Virus Enrollment Form

Please complete Patient and Prescriber information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

4 DIAGNOSIS AND CLINICAL INFORMATION

Patient's Gestational Age (required): _____ weeks _____ days Patient's Birth Weight: _____ g / kg / lbs (please circle)

Current Weight: _____ g / kg / lbs (please circle) Date Recorded: ___/___/_____

Did patient receive Synagis last season? ☐ No ☐ Yes Dates of Synagis doses given this season: _____

Multiple births: ☐ No ☐ Yes Enter names of Synagis candidates (submit separate enrollment forms): _____

Daycare attendance: ☐ No ☐ Yes School-age siblings in home: ☐ No ☐ Yes

NICU history: ☐ No ☐ Yes If yes, NICU name and include NICU summary: _____

Allergies: _____ Medical conditions not listed below: _____

Clinical Conditions: 2014 AAP Committee on Infectious Disease and Bronchiolitis Guidelines

Chronic Lung Disease (CLD):

☐ < 12 months of age with CLD*

☐ < 24 months of age with CLD* AND continues to require medical support during the 6-month period before second RSV season AND

☐ Supplemental oxygen (dates) _____ ☐ Chronic corticosteroids (drugs/dates) _____

☐ Diuretic therapy (drugs/dates) _____ ☐ Bronchodilators (drugs/dates) _____

*CLD of prematurely defined as gestational age < 31 weeks, 6 days AND requirement for 21% oxygen for at least the first 28 days after birth

Congenital Heart Disease (CHD):

☐ < 12 months of age at start of season with hemodynamically significant CHD such as:

☐ Acyanotic heart disease and receiving medication to control congestive heart failure and surgery to correct (meds/dates) _____ (surgery date) _____

☐ Moderate to severe pulmonary hypertension

☐ Other: describe _____

☐ < 24 months of age undergoing cardiac transplantation during the RSV season (date) _____

☐ Cyanotic Heart Disease: diagnosis _____

Airway/Neuro-muscular Conditions:

☐ < 12 months of age at start of season and compromised handling of secretions AND due to

☐ Significant abnormality of the airway (attach clinical notes) ☐ Neuromuscular condition (attach clinical notes)

Prematurity: ☐ < GA 28 wks, 6 days AND < 12 months at start of season

Other conditions: ☐ Other medical history (describe) _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Synagis (palivizumab)	50 mg and/or 100 mg vials	☐ Inject 15 mg/kg IM one time per month ☐ Other: _____	Quantity: QS to achieve 15 mg/kg dose Refills: _____
☐ Epinephrine	1:1000 amp	Inject 0.01 mg/kg SC as directed for anaphylaxis	Quantity: _____ Refills: 0

☐ Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED (Date)

X_____

DISPENSE AS WRITTEN (Date)

X_____

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record.