Respiratory Syncytial Virus

Prior Authorization Form/ Prescription

CARE 1ST HEALTH PLAN ARIZONA

Phone: 1-866-560-4042 (Options 5,5)
Fax: 1-602-778-8387

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-9/ICD-10 Code: _____

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

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 withoxygen 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 (888) 788-4408 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