



Telephone: 1-888-929-3790
 Fax: 1-866-399-0929

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

Date: _____ Date Medication Required: _____
 Ship to: Physician Patient's Home Other: _____

Patient Information

Last Name:		First Name:		Middle:	DOB: ___/___/___	
Address:				City:		State:
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:
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 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 (866) 296-8731 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