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Phone: 1-866-399-0928
Fax: 1-833-546-1508

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: 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 [redacted]

☐ 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 with oxygen 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: [redacted]

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**	**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