

Specialty Medication Review Program

Complete this form and fax to:

Medical Specialty Unit

Fax #: 1-800-306-0188

Phone #: 1-800-499-1275

If you are not **buying and billing** this medication, indicate which specialty pharmacy will be used:

☐ **Accredo Health**

Fax #: 1-888-773-7386

Phone #: 1-866-413-4137

☐ **Buy and Bill**

Complete ALL the following Patient/Prescriber Information: (Please Print)

Patient Information				
Patient Name:		Patient Phone #: ()		
Patient ID #:		Patient Birthdate:		
Secondary Insurer: (Name, Phone, ID #):				
List Patient Allergy (If Any)				
Prescriber Information				
Prescriber Name:		Prescriber Specialty:		
Prescriber Address:				
Prescriber Phone #:		Prescriber Fax #:		
Prescriber NPI #:		Office Contact:		Extension:
Location of Infusion: ☐ Prescriber office ☐ Home/Homecare agency: _____ ☐ Outpatient facility ☐ Other: _____				
Servicing Prescriber NPI (if different from the ordering prescriber):				
Provide address of infusion location above for medication shipping:				
Medication/Medical and Dispensing Information				
Medication (HCP/PCS)	Dose & Frequency	Height	Current Weight & Date (lbs./kgs)	Procedure Code
Synagis (90378)	Inject 15mg/kg IM once a month (Including ancillary supplies)	_____ inches	_____ / _____	
*Maximum 4 refills. Refills after April 1 st of the Synagis Season will require additional prior approval.				
1. Birth weight: lbs. _____ kgs: _____		2. Gestational Age: Weeks: _____ Days: _____		
3. Diagnosis/ICD-10: _____				
4. Indications of Medical Necessity: _____				
Questions/Indications for Medical Necessity				
** See the Synagis (Palivizumab) Policy (Pharmacy-51) for full Prior Authorization criteria ** *Note: All requests for RSV Prophylaxis will be required to use Beyfortus unless there is a medical reason why Beyfortus cannot be used and/or there is an ability to acquire Beyfortus. Beyfortus is covered without Prior Authorization.				
1. Does this patient have a medical reason why they cannot use Beyfortus?				☐ YES ☐ NO
*If yes, please explain the medical reason why Beyfortus cannot be used: _____				
2. Has there been an inability to acquire Beyfortus?				☐ YES ☐ NO
*If yes, please explain: _____				
(Complete Only One Box Which Best Describes Your Patient)				
1. Infants born prematurely				
a. Was the patient born at 29 weeks or less gestation age?				☐ YES ☐ NO
b. AND will the patient be less than 12 months chronological age at season start				
2. Congenital Heart Disease (CHD): **Provide recent cardiologist notes**				
a. Does the patient have hemodynamically significant congenital heart disease treated by a cardiologist?				☐ YES ☐ NO
b. Diagnosis: _____				
c. Medications: _____				
d. Surgical Procedure Required? *If yes, specify: _____				
e. AND will the patient be 12 months or less at season start?				☐ YES ☐ NO
3. Immunocompromised:				
a. Is the patient immunocompromised due to:				☐ YES ☐ NO
☐ Stem cell transplant (BMT, peripheral blood or cord blood) and less than 2 years old				
☐ Lung transplant and less than 2 years old				
☐ Severe combined immunodeficiency less than 2 years old				
☐ Any other severe immunodeficiency less than 2 years old? *If yes, specify: _____				☐ YES ☐ NO

Continue onto the next page

4. Neuromuscular disorder	
☐ Severe neuromuscular disorders AND ☐ Compromising handling of respiratory secretions AND ☐ Less than 12 months of age at season start	
5. Pulmonary abnormalities	
☐ Significant Congenital abnormalities of the airways AND ☐ Compromising handling of respiratory secretions AND ☐ Less than 12 months of age at season start	
6. Cystic Fibrosis (CF)	
☐ Child < 12 months at start of RSV season with diagnosis of CF AND nutritional compromise ☐ Child < 12 months at start of RSV season with chronic lung disease of prematurity - Was the patient born at 32 gestational weeks or less? - Did the patient require >21% Oxygen for at least the first 28 days of birth?	☐ YES ☐ NO ☐ YES ☐ NO
7. Second Season Request	
☐ Child < 24 months at start of RSV season with diagnosis of CF AND weight less than the 10 th percentile ☐ Child < 24 months at start of RSV season with diagnosis of CF AND manifestations of severe lung disease - Has this patient had previous hospitalization for pulmonary exacerbation in the 1st year of life? - Has this patient had abnormalities on chest radiography or chest CT that persist when stable?	☐ YES ☐ NO ☐ YES ☐ NO
Provide Other Comments/Clinical Justification:	

***ATTACH ANY CLINICAL NOTES RELATED TO THIS REQUEST. IF DOCUMENTATION IS NOT PROVIDED, IT MAY DELAY THE REQUEST**

*Prescriber Signature: _____ Date: _____

I certify the above is true and accurate to the best of my knowledge.