



Phone: 1-602-778-1800 (Options 5,5)
Fax: 1-602-778-8387

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

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

Table with 5 columns: MEDICATION, STRENGTH, DIRECTIONS, QUANTITY, REFILLS. Rows include Synagis and Epinephrine.

Prescriber has counseled parent/guardian on Synagis therapy and the specialty pharmacy may contact parent/guardian

Physician's Signature _____ Date: _____ DAW