SEND TO: ☐ AcariaHealth ☐ Specialty Pharmacy Provider: _____
Date: _____ Date Medication Required: _____
SHIP TO: ☐ Physician ☐ Patient's Home ☐ Other _____

illinicare health™

Telephone: 855-304-5580 **Fax:** 855-815-9894

RSV Prior Authorization Form

Patient Name: _____
Parent/Legal Guardian Name: _____
Address: _____
City: _____
State: _____ Zip:_____ County: _____
Home Phone: _____
Alt Phone: _____
Cell Phone: _____
Date of Birth: _____/_____/_____ Sex: ☐ Male ☐ Female
Patient Soc. Sec #: XXX-XX-_____ Allergies: _____

Physician Name: _____
State Lic #_____ DEA # _____
NPI # _____ UPIN# _____
Practice Name/Hospital: _____
Specialty: _____
Address: _____
City: _____ State: _____ Zip: _____
Physician's Ph: _____
Physician's Fax: _____
Nurse/Key Office Contact: _____ Direct Ext: _____

INSURANCE INFORMATION (Complete or Attach Copies of cards)

Primary Insurance:_____
City:_____State:_____
Plan #: _____
Group #: _____
Phone: (_____) _____-_____

Secondary Insurance:_____
City:_____State:_____
Plan #: _____
Group #: _____
Phone: (_____) _____-_____

Rx Card (PBM):_____
PBM BIN: _____
City:_____State:_____
Group #: _____
Phone: (_____) _____-_____

Cardholder First Name: _____
Last Name: _____
Employer: _____
ID #: _____
Group #: _____

CLINICAL INFORMATION AND MEDICAL ASSESSMENT

Diagnosis (Required):

☐ < 24 weeks of gestation (765.21)
☐ 24 weeks of gestation (765.22)
☐ 25-26 weeks of gestation (765.23)
☐ 27-28 weeks of gestation (765.24)
☐ 29-30 weeks of gestation (765.25)
☐ 31-32 weeks of gestation (765.26)
☐ 33-34 weeks of gestation (765.27)
☐ 35-36 weeks of gestation (765.28)
☐ 37 weeks+ of gestation (765.29)
☐ Cystic Fibrosis
☐ Congenital Heart Disease (Specify ICD-9) _____
☐ Chronic Respiratory Disease arising in the perinatal period (CLD) (770.7)
☐ Congenital Abnormality of Respiratory System (748.3-748.4)
☐ Other:_____

Patient Demographics:

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, please provide NICU name and attach discharge summary: _____
Was this season's first Synagis dose given in the NICU? ☐ Yes ☐ No If yes, please 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: 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
☐ Is the patient profoundly immunocompromised and less than 24 months at start of RSV season?
☐ Yes; Explain: _____ ☐ No
☐ Prematurity gestational age of ≤ 28 weeks, 6 days and less than 12 months at the start of the RSV season
☐ 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 866-329-4701 ext. 47716 for prior authorization
☐ Specialty Pharmacy to coordinate injection to coordinate injection training/home health nurse visit as necessary. Please list Agency of choice: _____

PRESCRIPTION INFORMATOIN

☐ Synagis® (palivizumab) 50 and/or 100mg vials Refills _____
  Sig: Inject 15mg/kg IM one time per month (Dose to be calculated at time of injection based on patient's current weight) Qty: QS to achieve 15mg/kg dose
☐ Epinephrine 1:1000 amp Refills _____ Sig: Inject 0.01 mg/kg subcutaneously as directed for anaphylaxis
☐ Prescriber has counseled parent/guardian on Synagis therapy and the specialty pharmacy may contact parent/guardian

Physician's Signature: _____ ☐ DAW (Dispense as Written) Date____/_____/____