Synagis

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Drug Information:

*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un

*Directions(sig)*_____ *Route of administration*_____

*Dosing frequency*_____

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Site of Service Questions:

A. Indicate the site of service requested:
- ❑ On Campus Outpatient Hospital
- ❑ Off Campus Outpatient Hospital
- ❑ Home based setting, *skip to Criteria Questions*
- ❑ Community office, *skip to Criteria Questions*
- ❑ Ambulatory infusion site, *skip to Criteria Questions*

B. Is the patient less than 18 years of age?
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No

C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre- medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

D. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

G. Has the patient's home been deemed not eligible or appropriate for home infusion services by a home infusion provider? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

H. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?
ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation. ❑ Yes ❑ No

Clinical Criteria Questions:

1. Does the patient have a diagnosis of prematurity (defined as gestational age less than or equal to 28 weeks, 6 days)? *If Yes, skip to #3* ❑ Yes ❑ No

2. What is the diagnosis?
   ❑ Chronic lung disease of prematurity
   ❑ Congenital heart disease (CHD)
   ❑ Congenital abnormality of the airway
   ❑ Neuromuscular condition
   ❑ Immunocompromised child
   ❑ Cystic fibrosis
   ❑ Other _____

3. What is the ICD-10 code? _____

4. Is the requested drug being used to prevent serious lower respiratory tract disease caused by RSV? ❑ Yes ❑ No

5. What was the patient's gestational age? _____ weeks, _____ days

6. What is the patient's chronological age (months) at the start of RSV season? _____ months

7. How many doses of the requested drug has the patient received this RSV season? _____ doses

8. Is this an off-season request for the requested drug? *If No, skip to diagnosis section* ❑ Yes ❑ No

9. According to the CDC National Respiratory and Enteric Virus Surveillance System (NREVSS), is the RSV activity ≥ 10% (with rapid antigen testing) or ≥ 3% (with real-time polymerase chain reaction (PCR) test) for the requested region or state within 2 weeks of the intended dose? ❑ Yes ❑ No

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Chronic Lung Disease of Prematurity

10. Does/Did the patient require greater than 21% oxygen for at least the first 28 days after birth? ❑ Yes ❑ No

11. *If the patient's chronological age at the start of RSV season is less than 12 months,* did the patient received the requested drug during the previous RSV season? ❑ Yes ❑ No *If No, no further questions*

12. Does the patient continue to require medical support during the 6-month period prior to the start of the current RSV season? ❑ Yes ❑ No

13. What is the treatment?
    ❑ Oxygen ❑ Diuretic ❑ Chronic corticosteroid ❑ Other _____

Section B: Congenital Heart Disease (CHD)

14. Is the CHD hemodynamically significant? ❑ Yes ❑ No

15. *If patient's chronological age at the start of RSV season is greater than or equal to 12 months,* is there a possibility that the patient will be undergoing cardiac transplantation during RSV season? ❑ Yes ❑ No

Section C: Congenital Abnormality of the Airway and Neuromuscular Condition

16. Does the patient's condition compromise handling of respiratory secretions? ❑ Yes ❑ No

Section D: Immunocompromised Patients

17. Is the patient profoundly immunocompromised (e.g., severe combined immunodeficiency [SCID], stem cell transplant, bone marrow transplant)? ❑ Yes ❑ No

Section E: Cystic Fibrosis

18. *If patient's chronological age at the start of RSV season less than 12 months,* does the member have evidence of chronic lung disease (CLD) or nutritional compromise? ❑ Yes ❑ No

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19. *If patient's chronological age at the start of RSV season is greater than or equal to 12 months,* does the member have manifestations of lung disease (e.g., hospitalizations for pulmonary exacerbations) or weight less than the 10th percentile? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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