Excellus

Specialty Medication Review Program

Synagis ®(Palivizumab)
Respiratory Syncytial Virus (RSV) Prophylaxis
Medical

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 (HCPCS)	**Dose & Frequency**	**Height**	**Current Weight & Date** (lbs./kgs)	**Procedure**
Synagis	**Inject 15mg/kg IM once a month (Including ancillary supplies)**			
*Maximum 4 refills. Refills after April 1st of the Synagis Season will require additional prior approval.				
Birth weight: lbs. _____ **kgs:** _____		**Gestational Age: Weeks:** _____ **Days:** _____		
Diagnosis/ICD-10:				
Indications of Medical Necessity: _____				
Has the patient received First Dose this season?				☐ **Yes** ☐ **No**

Questions/Indications for Medical Necessity	
** **See Respiratory Syncytial Virus (RSV) Prophylaxis Policy (Pharmacy-51) for full Prior Authorization criteria** **	
Complete Only One of the following Boxes Which Best Describes Your Patient & Provide The Necessary Documentation)	
Infants born prematurely	
a. Was the patient born at 29 weeks or less gestation age? **AND** will the patient be less than 12 months chronological age at season start	☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**
Congenital Heart Disease (CHD): **Provide recent cardiologist notes**	
a. Does the patient have hemodynamically significant congenital heart disease treated by a cardiologist? Diagnosis: _____ b. Medications: _____ c. Surgical Procedure Required? If yes, please specify: _____ d. **AND** will the patient be 12 months or less at season start?	☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**
Immunocompromised	
Is the patient immunocompromised due to: ☐ 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	☐ **Yes** ☐ **No**

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Neuromuscular disorder	
☐ Severe **neuromuscular disorders** & ☐ Compromising handling of respiratory secretions & ☐ Less than 12 months of age at season start	☐ **Yes** ☐ **No**
Pulmonary abnormalities	
☐ Significant Congenital abnormalities of the airways & ☐ Compromising handling of respiratory secretions & ☐ Less than 12 months of age at season start	☐ **Yes** ☐ **No**
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**
Second Season Request	
☐ Child < 24 months at start of RSV season with diagnosis of CF **AND** weight less than the 10th 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 that the above is true and accurate to the best of my knowledge.