buckeye health plan

Telephone: (866) 246-4356
Fax: (855) 678-6976

Respiratory Syncytial Virus
Prior Authorization Form/ Prescription

Date: _____ Date Medication Required:_____
Ship to: m Physician m Patient's Home m 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
- ☐ < 24 weeks of gestation
- ☐ 29-30 weeks of gestation
- ☐ 37+ weeks of gestation
- ☐ Chronic Respiratory disease arising in the perinatal period
- ☐ 24 weeks gestation
- ☐ 31-32 weeks of gestation
- ☐ Other _____
- ☐ Congenital Abnormality of Respiratory System
- ☐ 25-26 weeks of gestation
- ☐ 33-34 weeks of gestation
- ☐ Cystic Fibrosis
- ☐ 27-28 weeks of gestation
- ☐ 35-36 weeks of gestation

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 withoxygen 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 (866) 296-8731 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

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Synagis	☐50mg ☐100mg	Inject 15 mg/kg IM one time per month		
Epinephrine	1:1000 amp	Inject 0.01 mg/kg subcutaneously as directed		

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

Physician's Signature _____ **Date:** _____ ☐ DAW