Synagis

Prior Authorization Request

CVS Caremark administers the medical drug prior authorization program on behalf of Harvard Pilgrim Health Care. 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 to CVS Caremark, toll-free at 1-844-851-0882** to initiate the review process. If you have questions regarding the prior authorization please contact CVS Caremark at **1-844-387-1435.**

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Patient's Name: ______________________________ **Date**: ____________________________________
Patient's ID: ________________________________ **Patient's Date of Birth:** __________________
Physician's Name: ____________________________ **NPI#:** ____________________________________
Specialty: ___________________________________ **HPHC Provider ID**________________________
Physician Office Telephone: __________________ **Physician Office Fax:** _____________________

Rendering Provider Info: ❑ **Same as Requesting Provider** **HPHC Provider ID:**________________________
Name: ____ **NPI#:** ___________________________________
Fax: _____________________ **Phone:** __________________ **Provider Tax ID:** ______________________

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

Additional Demographic Information:

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Inpatient Hospital* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Drug Information:

*Strength/Measure*______________________________ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*________________________________ *Route of administration*________________________
*Dosing frequency*______________________________

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-844-851-0882

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Synagis HPHC – 10/2018.

Criteria Questions:

1. What is the diagnosis?
   ❑ Prematurity
   ❑ Chronic lung disease of prematurity
   ❑ Congenital heart disease (CHD)
   ❑ Congenital abnormality of the airway
   ❑ Neuromuscular condition
   ❑ Other ____

2. What is the ICD-10 code? _____________
   If patient's diagnosis is anything other than chronic lung disease of prematurity, skip to #5.

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

4. Which of the following has the patient been treated with during the 6 month period prior to the start of the RSV season?
   ❑ Oxygen
   ❑ Diuretics
   ❑ Chronic corticosteroid
   ❑ Other ____
   ❑ None of the above

5. What is the gestational age? _________ weeks, __________ days

6. What is the chronological age (months) at the start of RSV season?
   Note: If infant was born on or after the season start date, indicate zero. __________________ months

7. Is Synagis being used to prevent serious lower respiratory tract disease caused by RSV? ❑ Yes ❑ No

8. Is this an off-season request for Synagis? ❑ Yes ❑ No

9. How many doses of Synagis has the patient received this RSV season? ___________

10. *If this is off-season request for Synagis,* according to the CDC National Respiratory and Enteric Virus Surveillance System (NREVSS), is the RSV activity greater than or equal to 10% for the requested region 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

11. *If chronological age at the start of RSV season is less than 12 months,* has the patient received Synagis for the previous RSV season? ❑ Yes ❑ No

Section B: Congenital Heart Disease (CHD)

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

13. *If chronological age at the start of RSV season is greater than or equal to 12 months to less than 24 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, Neuromuscular Condition

14. Does the patient's condition compromise handling of respiratory secretions? ❑ 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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