

November 4, 2010

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RSV UPDATE

As RSV season approaches, it is important to make arrangements to ensure that children who need Synagis® receive injections. Care1st will work with your office to authorize and obtain Synagis® with no out of pocket cost.

The guidelines for Synagis® administration are included on the Care1st RSV Prophylaxis Eligibility Assessment Form (ie. Care1st Synagis Form) and is attached for your reference. The Care1st Synagis Form will also be used as the prior authorization form. All Synagis® requests require prior authorization. To obtain prior authorization:

- Please complete the Care1st RSV Prophylaxis Eligibility Assessment Form and fax it to 602.778.1838 with progress notes. We will review and process your request as quickly as possible.
- Once your request is approved, you may contact the Los Niños Synagis® Program at 602.424.2146 to schedule an appointment.
- The *Care1st Synagis Form* is also available on our website www.care1st.com/az under the Forms section of the Provider drop down menu.

Please contact the *Care1st Pharmacy Department* at 602.778.1800 Options 5, 5 if you have any questions.

Thank you!



CARE1ST RSV PROPHYLAXIS ELIGIBILITY ASSESSMENT FORM

FAX TO: Care1st Pharmacy Dept. 602.778.1838

QUESTIONS: 602.778.1800 (Options 5,5)

Incomplete Forms Will Be Returned

PATIENT INFORMATION

Patient Name: _____	Patient AHCCCS #: _____
Patient DOB: _____	Patient Phone # with Area Code: _____

PRESCRIBER INFORMATION

Prescriber Name: _____	NPI #: _____	License #: _____
Phone # w/Area Code: _____	Fax # w/Area Code: _____	
Address: (Optional) _____		
Address/City/State/Zip		

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Required supporting documentation from the patient's medical record is attached.

Prescribing Practitioner Signature (Required)

Date

DRUG/CLINICAL INFORMATION

Drug requested: _____	NDC/J Code: _____
Strength: _____	Qty. per month: _____
Current Weight: _____ kg.	Gestational age: _____
Wks: _____	Days: _____
ICD-9 Codes: _____	Chronological age: _____
Number of doses requested: _____	

Check applicable age, condition and risk factors

- Gestational age \leq 28 wks, 6 days & infant is < 12 months'
- Gestational age 29 wks, 0 days-31 wks, 6 days & infant is < 6 months'
- Gestational age 32 wks, 0 days-34 wks, 6 days & infant < 3 months old at the start of RSV season OR born during the RSV season with one of the two AAP risk factors*
- Gestational age < 35 wks & infant < 12 months' with congenital abnormalities of the airway or neuromuscular disease that compromises handling of respiratory secretions**

- Child is < 24 months' old with Chronic Lung Disease** of prematurity (gestational age < 35 wks)
- Child is \leq 24 months' old with hemodynamically significant (cyanotic or acyanotic) Congenital Heart Disease ** (must not have had or completed surgical correction)
 - *Chronological age at start of RSV season
 - *Document AAP risk factor(s) below
 - **Include ICD-9 codes for the indicated disease states. Attach supporting documentation (i.e. progress notes, discharge notes, and/or chart notes) as outlined in the criteria for any submitted diagnosis/ICD-9 code

AND

Is patient currently outpatient with no inpatient stay in the last 2 weeks? Yes No If no, indicate discharge date: _____

Was a dose of Synagis* administered while patient was hospitalized? Yes No If yes, indicate date dose administered: _____

List all AAP recognized risk factors/Medical justification/Reference attached supporting documentation

List all Medications (Include medication name, start date, and end date for diagnoses that require acceptable medical therapy)

Authorization does not guarantee payment. Please verify eligibility prior to rendering service. Payment will not be made for unauthorized services.

ALL APPROVED SYNAGIS SERIES ARE DIRECTED TO THE LOS NIÑOS SYNAGIS PROGRAM