CARE 1ST HEALTHPLAN ARIZONA
"Diverse Health Care for Diverse Needs"

October 13, 2011

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!

Provider Network Operations
Phone 602.778.1800 or 866.560.4042 (Options in order: 5, 7)
Fax 602.778.1875
Visit our website at www.care1st.com/az

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: __________ Number of doses requested: _________
Current Weight: ________ kg. Gestational age: ________ Wks: ______ Days: ______ Chronological age: _________
ICD-9 Codes: ____

Check applicable age, condition and risk factors

☐ Gestational age ≤ 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 <u>OR</u> 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 ≤ 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.

A new Prior Authorization request must be submitted for dosage increases.

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

Revised 11.2011