



RSV PROPHYLAXIS ELIGIBILITY ASSESSMENT FORM

FAX TO: Care1st Pharmacy Dept. 602.778.8387

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 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.

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

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