OPTUM®

Fax: 866-391-1890

Phone: 888-293-9309

RSV / Synagis Enrollment / Prescription Form

*Please complete this form for members needing a Synagis prescription and fax it to BriovaRx at **866-391-1890**. BriovaRx, a network specialty pharmacy, will notify you and your patient of prescription coverage. This form helps determine if the patient's condition meets drug policy guidelines, so please fill it out completely. Any missing information may cause a delay in the coverage decision. If you have questions or need to request a refill, please contact BriovaRx at **888-293-9309.***

For all REFILL requests, please call 888-293-9309

PATIENT INFORMATION *(Section must be completed to process prescription)*

Patient Name ______________________ DOB ____________ Gender: ☐ M ☐ F

Parent / Guardian ______________________ Last Four of SS# __________ Home Phone ____________

Address ______________________ Alternate Phone ____________

City ____________ State & ZIP ____________ Language Preference: ☐ English ☐ Spanish ☐ Other ____________

INSURANCE INFORMATION *(Must fax a copy of patient's insurance card including both sides)*

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PHYSICIAN INFORMATION AND PRESCRIPTION FOR SYNAGIS

Referring Physician ______________________ NPI # ____________

Practice Name ______________________ DEA # ____________

Address ______________________ Phone # ____________

Medicaid Prescriber # ____________ Office Contact ____________ Fax # ____________

NEXT injection OR FIRST injection due. Date ________ Has first dose been given? ☐ Yes ☐ No If Yes, When? ________ Where? ________

Subsequent injections will be administered in: ☐ Hospital ☐ MD Office ☐ Patient's Home ☐ Other ____________

☐ Check here to have us coordinate nursing for in-home injections. *(service available in select regions)*

Preferred home health agency, if any ____________ Already in the home? ____________

PRESCRIPTION INFORMATION

Medication	Strength	Directions	Quantity	Total Doses Requested
☐ Rx Synagis®	50 and/or 100mg vials	Inject 15mg/kg IM one time per month	Other: QS to achieve15mg/kg dose	
☐ Rx Epinephrine	1:1000 amp	Inject 0.01 mg/kg subcutaneously as directed for anaphylaxis	QS	

Which months are requested for the current season? (Circle) Nov. Dec. Jan. Feb. Mar. Other (specify) ____________

Allergies: ☐ Yes ☐ No If Yes, please list: ____________

Other medical history: ____________

Has the child been previously approved for Synagis by another insurance carrier for the current season? ☐ Yes ☐ No
(Please attach approval from previous insurance carrier and clinical notes for doses already given)

****Prescriber Authorization:*** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

☐ Product Substitution permitted ☐ Dispense as Written

Prescriber's Signature ______________________ Date ________ Supervising physician ______________________ Date ________

See next page

MEDICAL INFORMATION

ICD-10 Code: ______________________ Diagnosis: ______________________

ICD-10 Code: ______________________ Diagnosis: ______________________

List Meds and Dates ______________________ Ventilator and Dates ______________________

CLINICAL INFORMATION

Patient's Gestational Age (Required): __________ Weeks ____________ Days

Patient is a multiple birth: ☐ Yes ☐ No

• Current weight in: ____________ kilograms (kg) ____________ pounds (lbs) Date recorded: ______________________

☐ Yes ☐ No RequestAWill Synagis be administered during RSV season as defined by Centers for Disease and Prevention (CDC) surveillance reports or state or local health departments to confirm the start of the respiratory syncytial virus (RSV) "season"?

☐ Yes ☐ No Will the monthly dose of Synagis exceed 15 mg/kg per dose?

☐ Yes ☐ No Congenital abnormalities of the airway or neuromuscular disease/ Immunocompromised children and < 24 months of age

Chronic lung disease (CLD): ☐ Yes ☐ No ICD-10 Code: ______________________ (attach medical history)

☐ Yes ☐ No Did the preterm infant develop chronic lung disease (CLD) of prematurity defined as gestational age < 32 weeks, 0 days and a requirement for >21% oxygen for at least the first 28 days after birth?

☐ Yes ☐ No Is the infant born at < 32 weeks, 0 days gestation who are ≥ 12 to < 24 months of age and required at least 28 days of oxygen after birth and who continue to require supplemental oxygen, diuretics, or chronic systemic corticosteroid therapy within 6 months of the start of the second RSV "season?"

☐ Yes ☐ No Did the preterm infant develop chronic lung disease (CLD) of prematurity defined as gestational age < 32 weeks, 0 days and a requirement for >21% oxygen for at least the first 28 days after birth?

☐ Yes ☐ No Is the infant born at < 32 weeks, 0 days gestation who are ≥ 12 to < 24 months of age and required at least 28 days of oxygen after birth and who continue to require supplemental oxygen, diuretics, or chronic systemic corticosteroid therapy within 6 months of the start of the second RSV "season?"

Congenital heart disease (CHD): ☐ Yes ☐ No ICD-10 Code: ______________________ (attach medical history)

☐ Yes ☐ No Acyanotic heart disease

Which of the following does the child/infant have?

☐ A. Acyanotic heart disease and receiving medication to control congestive heart failure and will require cardiac surgical procedures
☐ B. Moderate to severe pulmonary hypertension
☐ C. Cyanotic heart defects
☐ D. Other______________________

☐ Yes ☐ No Was decision for Synagis prophylaxis in infant with cyanotic heart defects in the first year of life made by or in consultation with a pediatric cardiologist?

☐ Yes ☐ No Did the child undergo cardiac transplantation during the RSV "season"?

☐ Yes ☐ No Congenital abnormalities of the airway or neuromuscular disease: A. Age 0 to < 12 months B: Other age

☐ Yes ☐ No Does the infant/child have impaired ability to clear secretions from the lower airway because of ineffective cough?

☐ Yes ☐ No Immunocompromised and < 24 months of age: Is the Child receiving cancer chemotherapy or is severely immunocompromised?

• List cardiac medications:

______________________ Last date received: ____________

______________________ Last date received: ____________

______________________ Last date received: ____________

Cystic Fibrosis: ☐ Yes ☐ No ICD-10 Code: ______________________ (attach medical history)

☐ Yes ☐ No Age 0 to <12 months: Does the infant/child have clinical evidence of Chronic lung disease (CLD) and/or nutritional compromise in the first year of life? Note: Failure to thrive is defined as weight for length less than the 10th percentile on a pediatric growth chart.

☐ Yes ☐ No age > 12 to 24 months: For second year treatment, does infant/child have manifestations of severe lung disease including one of the following: A. Previous hospitalization for pulmonary exacerbation in the first year of life. B. Abnormalities on chest radiography or chest computed tomography that persists when stable. C. Weight for length less than the 10th percentile on a pediatric growth chart.

Prematurity:

☐ Yes ☐ No Is the infant born before 29 weeks, days gestation and is < 12 months of age at the start of RSV season?