FIDELIS CARE

REQUEST FOR SYNAGIS FOR RESPIRATORY SYNCYTIAL VIRUS (RSV) – NEW JERSEY

FAX TO: 1-888-340-9512

1. PATIENT INFORMATION *To be completed by the Physician and Staff*

Last Name | First Name | M.I.

Street Address

City | State | ZIP

Day Telephone # (+Area Code) | Mobile Telephone # (+Area Code)

Date of Birth (MM/DD/YYYY) | **Member ID Number** | Sex (Check One) ☐ M ☐ F

Parent/Guardian Name

2. PHYSICIAN INFORMATION *To be completed by the Physician and Staff*

Prescriber's Last Name | Prescriber's First Name

Office Contact

Street Address

City | State | ZIP

Telephone # (+Area Code) | Fax # (+Area Code)

Provider ID Number | DEA #

Primary Care Physician Name | Phone #

PHC3499-0606

RX

☐ **Synagis® (palivizumab)** 50 and/or 100 mg Vials ☐ NKDA

Sig: Inject 15 mg/kg IM Once Monthly

Dispense Quantity: QS ☐ Refill _____ Months

☐ Other: _____

Expected Date of First/Next Injection _____

Deliver Product to: ☐ Office ☐ Home Please send Synagis to office location above: ☐ Yes ☐ No

Will Agency Nurse Visit Home for Injection? ☐ Yes ☐ No

Fidelis Care has criteria for Synagis Treatment in the member's home. Please contact Fidelis Care Injectable Department for this information. Fidelis Care does not cover Synagis given by non-participating pharmacies/nursing agencies.

Prescriber's Signature_____ **Date**

Date of Request: _____

STATEMENT OF MEDICAL NECESSITY

Patient's Gestational Age _____Wks ____ Days____ Birth Weight _____ g/kg/lbs
Current Weight _____ g/kg/lbs Date Recorded _____

Please Document All Diagnoses and Document to the Highest Degree of ICD-10
Detail MEDICAL CRITERIA:

1. Diagnosis of Chronic Pulmonary Disease (CLD/BPD) & less than 24 months of age at Start of RSV Season? ☐ Yes ☐ No ICD-10 _____
Is Patient Receiving Medical Treatment of:
(Check all that apply and provide last date received)
☐ Oxygen Date _____ ☐ Corticosteroids Date _____
☐ Bronchodilator Date _____ ☐ Diuretics Date _____

2. Diagnosis of Hemodynamically Significant Congenital Heart Disease and less than 24 months of age at Start of RSV Season? ☐ Yes ☐ No ICD-10 _____
Patient HAS the following conditions:
☐ Diagnosis of Moderate to Severe Pulmonary Hypertension
☐ Cyanotic Heart Disease ☐ Acyanotic Heart Disease
☐ Medications for CHF _____Last Received: _____

3. Prematurity
☐ Gestational Age of ≤ 28 Weeks & ≤ 12 Months at the Start of RSV Season
☐ Gestational Age of 29 Weeks – 31 Weeks, 6 days & ≤ 6 Months at the Start of RSV Season
☐ Gestational Age of 32 Weeks – 34 Weeks, 6 Days & ≤ 3 months at the Start of RSV Season **AND** Has ONE of the following Risk Factors:
(Check All That Apply)
☐ Child Care/Day Care Attendance ☐ Siblings younger than 5 yrs of age
☐ Severe Neuromuscular Disease (Neurological Disorders)
☐ Congenital Abnormalities of the Airway

OTHER MEDICAL HISTORY:

Additional Information:
Received Previous Injections this Season? ☐ Yes ☐ No Date _____
Was Synagis Authorized by Prior Insurance Plan this Season? ☐ Yes ☐ No
Insurance Company Name:_____ ID # _____

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.

Rev. 08/09

NJ3JMDFRM24004E_0000