Synagis

HMSA - Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-237-5512**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Patient's Phone Number: _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*ft* _____*inches*

Indicate where the drug is being dispensed:

❑ Office ❑ Outpatient Hospital ❑ Ambulatory Surgical ❑ Inpatient Hospital
❑ Off Campus Outpatient Hospital ❑ Urgent Care ❑ Emergency Room ❑ Birthing Center
❑ Military Facility ❑ Skilled Nursing Facility ❑ Nursing Facility ❑ Hospice
❑ Inpatient Psychiatric ❑ Psychiatric Residential Treatment ❑ End Stage Renal Facility
❑ Psychiatric Facility ❑ Pharmacy ❑ Other

Indicate where the drug is being administered:

❑ Ambulatory surgical ❑ Home ❑ Inpatient Hospital
❑ Office ❑ Outpatient Hospital ❑ Pharmacy

What is the ICD-10 code? _____

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512

Criteria Questions:

1. Is Synagis being used to prevent serious lower respiratory tract disease caused by RSV?
   - ❒ Yes, *Continue to #2*
   - ❒ No, *Continue to #2*

2. What is the diagnosis?
   - ❒ Chronic lung disease of prematurity, *Continue to #3*
   - ❒ Congenital heart disease (CHD) and/or persistent pulmonary hypertension, *Continue to #8*
   - ❒ Congenital abnormality of the airway, *Continue to #11*
   - ❒ Neuromuscular condition, *Continue to #11*
   - ❒ Prematurity, *Continue to #12*
   - ❒ Immunocompromised patients, *Continue to #14*
   - ❒ Other, *No Further Questions*

3. What was the patient's gestational age? Note: In some cases, birth records may be requested to verify gestational age

   _____ weeks, _____days, *Continue to #4*

4. Does the patient require >21% oxygen for at least the first 28 days after birth?
   - ❒ Yes, *Continue to #5*
   - ❒ No, *Continue to #5*

5. What is the patient's chronological age at the start of RSV season?
   - ❒ <12 months, *Continue to #16*
   - ❒ 12 to <24 months, *Continue to #6*
   - ❒ ≥24 months, *No Further Questions*

6. Does the patient continue to require medical support during the 6-month period prior to the start of the 2nd RSV season?
   - ❒ Yes, *Continue to #7*
   - ❒ No, *Continue to #7*

7. What is the treatment?
   - ❒ Oxygen, *Continue to #16*
   - ❒ Diuretic, *Continue to #16*
   - ❒ Chronic corticosteroid, *Continue to #16*
   - ❒ Other, please specify _____ *No Further Questions*

8. Is the CHD and/or persistent pulmonary hypertension hemodynamically significant?
   - ❒ Yes, *Continue to #9*
   - ❒ No, *Continue to #9*

9. What is the patient's chronological age at the start of RSV season?

❒ <12 months, *Continue to #16*

❒ 12 to <24 months, *Continue to #10*

❒ ≥24 months, *No Further Questions*

10. Is there a possibility that the patient will be undergoing cardiac transplantation during RSV season?

❒ Yes, *Continue to #16*

❒ No, *Continue to #16*

11. Does the patient's condition compromise handling of respiratory secretions?

❒ Yes, *Continue to #13*

❒ No, *Continue to #13*

12. What was the patient's gestational age? Note: In some cases, birth records may be requested by CVS Caremark to verify gestational age

_____ weeks, _____ days, *Continue to #13*

13. What is the patient's chronological age at the start of the RSV season?

❒ <12 months of age, *Continue to #16*

❒ ≥12 months of age, *Continue to #16*

14. Is the patient severely immunocompromised (e.g., recently received a solid organ transplant, chemotherapy)?

❒ Yes, *Continue to #15*

❒ No, *Continue to #15*

15. What is the patient's chronological age at the start of the RSV season?

_____ weeks, _____ days, *Continue to #16*

16. Is this an off-season request for Synagis? Note: HMSA RSV season dates are August 1 to February 29

❒ Yes, *Continue to #20*

❒ No, *Continue to #17*

17. How many doses of Synagis has the patient received this RSV season?

_____ doses, *Continue to #18*

18. Has the patient undergone cardiopulmonary bypass during the RSV season?

❒ Yes, *Continue to #19*

❒ No, *Continue to #19*

19. Is this request for an additional dose within a few days after cardiopulmonary bypass?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

20. According to the CDC National Respiratory and Enteric Virus Surveillance System (NREVSS), is the RSV activity > 10% for the requested region?

❒ Yes, *Continue to #21*

❒ No, *Continue to #21*

21. How many doses of Synagis has the patient received this RSV season?

_____ doses

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**