CAREMARK ENROLLMENT FORM

RESPIRATORY SYNCYTIAL VIRUS (RSV)

CAREMARKCONNECT®

TEL (800) 237-2767 FAX (800) 323-2445

1 PATIENT INFORMATION

Last Name | First Name | Middle Initial

Street Address | City/State/Zip Code

Day Telephone (+Area Code) | Night Telephone (+Area Code)

❑ M ❑ F

Date of Birth | Social Security Number | Sex (✔ One)

Parent/Guardian Name

INSURANCE INFORMATION

Please include copies of the patient's insurance cards (front & back) when faxing the referral to expedite benefit clearance.

Primary Medical Insurance | Pharmacy Insurance | Secondary Medical Insurance

Cardholder Name & Social Security Number (If Not Patient) | Cardholder Name & Social Security Number (If Not Patient)

PLEASE INCLUDE COPIES OF INSURANCE CARDS

Group/Policy Number | Group/Policy Number

Insurance Telephone Number (+ Area Code) | Insurance Telephone Number (+ Area Code)

Employer | Medicaid Number

Caremark is committed to protecting the privacy of your health information. We will hold your health information in confidence and will only use and disclose it in accordance with applicable law.

2 PHYSICIAN INFORMATION

Prescriber's Name | Hospital/Clinic | **Office Contact Name**

Address | City/State/Zip | Telephone Number (+Area Code)

Prescriber's License Number | DEA Number | Fax Number (+Area Code)

UPIN # | Medicaid License Number

Supervising Physician's Name (If Required for Mid-Level Practitioner) | License Number

Primary Care Physician's Name if other than Original Prescriber | **Phone Number**

PHC3499-0606

CAREMARK® *It all starts with care®*

Thank you for choosing Caremark!

STATEMENT OF MEDICAL NECESSITY

PRIMARY DIAGNOSIS

Patient's Gestational Age: _____ weeks _____ 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-9 detail

❑ Congenital Heart Disease _____ please specify (don't enter ICD9 codes)

❑ Chronic Respiratory Disease Arising in the Perinatal Period (CLD) (770.7) ❑ ≤ 24 weeks of gestation (765.21 - 765.22)

❑ 25-26 weeks of gestation (765.23) ❑ 27-28 weeks of gestation (765.24)

❑ 29-30 weeks of gestation (765.25) ❑ 31-32 weeks of gestation (765.26)

❑ 33-34 weeks of gestation (765.27) ❑ 35-36 weeks of gestation (765.28)

❑ 37 weeks of gestation (765.29) ❑ Congenital Abnormality of Respiratory System (748.3 - 748.4)

❑ Other Respiratory Conditions of Fetus and Newborn (770.0 - 770.9)

❑ Other _____ Secondary diagnosis (if applicable): _____

MEDICAL CRITERIA:

1. Diagnosis of Chronic Pulmonary Disease (CLD/BPD) and less than 24 months of age? ❑ No ❑ Yes ICD-9: _____
   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? ❑ No ❑ Yes ICD-9: _____
   Patient has the following conditions: ❑ Diagnosis of moderate-severe pulmonary hypertension
   ❑ Cyanotic heart disease ❑ Acyanotic heart disease
   ❑ Medications for CHF: _____ Last date received: _____
3. Prematurity: ❑ Gestational age of ≤ 28 weeks, 0 days and less than 12 months of age at the start of Synagis season
   ❑ Gestational age of 28 weeks, 1 day - 32 weeks, 0 days and less than 6 months at the start of Synagis season
   ❑ Gestational age of 32 weeks, 1 day - 35 weeks, 0 days AND ❑ less than 6 months at the start of Synagis season
   ❑ has two or more risk factors ❑ has NO risk factors

Has the following risk factors (check all that apply): ❑ Child Care Attendance ❑ School-Aged Siblings _____ specify age(s)
❑ Severe neuromuscular disease ❑ Exposure to Environmental Air Pollutants: (❑ Includes Smoking ❑ Excludes Smoking)
❑ Congenital Abnormalities of Airway ❑ None ❑ Other _____

OTHER MEDICAL HISTORY:

_____

Additional Clinical Information: ❑ Multiple Births

NICU HISTORY: ❑ No ❑ Yes: NICU Name _____ **Please attach the NICU Discharge Summary**

Was there a NICU dose administered? ❑ No ❑ Yes Date(s): _____

Did the neonatologist recommend Synagis prior to discharge? ❑ No ❑ Yes

Expected date of first/next injection: _____ Previous injections? ❑ No ❑ Yes Date(s): _____

Deliver product to: ❑ Office ❑ Home

Agency Nurse to visit home for injection? ❑ No ❑ Yes

Rx

❑ **Synagis® (palivizumab)** 50 and/or 100 mg vials ❑ NKDA

Sig: Inject 15mg/kg IM one time per month

Dispense Quantity: QS Refill _____ months

❑ Other _____ ❑ Dispense as Written

Sig: _____ ❑ Substitution Allowed

Prescriber's Signature: **Date:**

Supervising Physician's Signature: **Date:**

3 FAX COMPLETED FORM TO CAREMARKCONNECT® AT 1-800-323-2445

Please include copies of the patient's insurance cards (front & back) when faxing the referral to expedite benefit clearance.