Synagis

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 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** 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:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

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

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

Criteria Questions:

1. Does the patient have a diagnosis of prematurity (defined as gestational age less than or equal to 28 weeks, 6 days)? *If Yes, skip to #3* ❑ Yes ❑ No

2. What is the diagnosis?
   ❑ Chronic lung disease of prematurity
   ❑ Congenital heart disease (CHD)
   ❑ Congenital abnormality of the airway
   ❑ Neuromuscular condition
   ❑ Immunocompromised child
   ❑ Cystic fibrosis
   ❑ Other _____

3. What is the ICD-10 code? _____

4. Is the requested drug being used to prevent serious lower respiratory tract disease caused by RSV? ❑ Yes ❑ No

5. What was the patient's gestational age? _____ weeks, _____ days

6. What is the patient's chronological age (months) at the start of RSV season? _____ months

7. How many doses of the requested drug has the patient received this RSV season? _____ doses

8. Is this an off-season request for the requested drug? *If No, skip to diagnosis section* ❑ Yes ❑ No

9. According to the CDC National Respiratory and Enteric Virus Surveillance System (NREVSS), is the RSV activity ≥ 10% (with rapid antigen testing) or ≥ 3% (with real-time polymerase chain reaction (PCR) test) for the requested region or state within 2 weeks of the intended dose? ❑ Yes ❑ No

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Chronic Lung Disease of Prematurity

10. Does/Did the patient require greater than 21% oxygen for at least the first 28 days after birth? ❑ Yes ❑ No

11. *If the patient's chronological age at the start of RSV season is less than 12 months,* did the patient received the requested drug during the previous RSV season? ❑ Yes ❑ No *If No, no further questions*

12. Does the patient continue to require medical support during the 6-month period prior to the start of the current RSV season? ❑ Yes ❑ No

13. What is the treatment?
    ❑ Oxygen ❑ Diuretic ❑ Chronic corticosteroid ❑ Other _____

Section B: Congenital Heart Disease (CHD)

14. Is the CHD hemodynamically significant? ❑ Yes ❑ No

15. *If patient's chronological age at the start of RSV season is greater than or equal to 12 months,* is there a possibility that the patient will be undergoing cardiac transplantation during RSV season? ❑ Yes ❑ No

Section C: Congenital Abnormality of the Airway and Neuromuscular Condition

16. Does the patient's condition compromise handling of respiratory secretions? ❑ Yes ❑ No

Section D: Immunocompromised Patients

17. Is the patient profoundly immunocompromised (e.g., severe combined immunodeficiency [SCID], stem cell transplant, bone marrow transplant)? ❑ Yes ❑ No

Section E: Cystic Fibrosis

18. *If patient's chronological age at the start of RSV season less than 12 months,* does the member have evidence of chronic lung disease (CLD) or nutritional compromise? ❑ Yes ❑ No

19. *If patient's chronological age at the start of RSV season is greater than or equal to 12 months,* does the member have manifestations of lung disease (e.g., hospitalizations for pulmonary exacerbations) or weight less than the 10th percentile? ❑ Yes ❑ No

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)**

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

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