Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462 (800.88.CIGNA)

Synagis
(palivizumab)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed*		
Specialty:	* DEA, NPI or TIN:		* Patient Name:		
Office Contact Person:			* Cigna ID:	* Date of Birth:	
Office Phone:			* Patient Street Address:		
Office Fax:			City:	State:	Zip:
Office Street Address:			Patient Phone Number:		
City:	State:	Zip:			

PRESCRIPTION INFORMATION

Urgency:
☐ Standard
☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

SYNAGIS® (Palivizumab 90378): ☐Inject 15 mg/kg IM once monthly	Refills (months): ☐Through March of current RSV season ☐Other:	EXPECTED DATE OF INJECTION (MM/DD/YY) *Required to ensure accurate dispensing:*
☐Other:	Qty: 1 Refill: ☐Other:	

Please note type of Auth Request

☐ Pre-Season: *If you are requesting pre-season dosing for your locale, please provide justification necessitating early administration and include supporting data from the CDC or local health department supporting an early start date to Synagis season.*

☐ Current Season: *RSV season begins in November and ends in March for most of the US. If you are requesting in-season dosing outside of these months, please provide justification.*

☐ Post Season: *Please include virology data from the CDC if additional doses are needed.*

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Is this infusion occurring in a facility affiliated with hospital outpatient setting? Yes ☐ No ☐

If yes- Is this patient a candidate for re-direction to an alternate setting after 1-2 infusions (such as AIS, MDO, home) with assistance of a Specialty Care Option Case Manager? Yes ☐ No ☐

NOTE: Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting.

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Which of the following uses applies to your patient? ICD10:

What is the patient's diagnosis or reason for use?

☐ Prevention of RSV
☐ Treatment of RSV
☐ All other

Clinical Data:
Infant / child's Weight: _________ Date recorded: _________

Gestational age at birth: ________ weeks _________ days

Please provide anticipated month of start of RSV season in patient's residence area:

Please specify the number of injections you are requesting:

What is the start date of therapy? What is the end date of therapy?

Please note: *If you are requesting pre-season dosing for your locale, please provide justification necessitating early administration and include supporting data from the CDC or local health department supporting an early start date to Synagis season.*

**Typically, RSV season begins in November and ends in March. However, the duration of the Synagis season remains 5 consecutive months for all geographic areas in the United States.

Does your patient have one of the following conditions?
☐ anatomic pulmonary abnormalities or a neuromuscular disorder
☐ cardiac transplant (these patients may also be immunocompromised, please also complete immunocompromised section)
☐ chronic lung disease
☐ congenital heart disease
☐ immunocompromised (Please Note: Examples of immunocompromised patients include those receiving chemotherapy and those with hematopoietic stem cell transplant or solid organ transplant. A patient with cardiac transplant may also be immunocompromised.)
☐ premature birth
☐ None of the above

if chronic lung disease

What is the age of the patient at the start of the RSV season?
☐ Less than 12 months of age
☐ Greater than or equal to 12 months of age but less than 24 months of age
☐ Greater than or equal to 24 months of age

Was the patient born at less than 32 weeks, 0 days gestation? ☐ Yes ☐ No

Did the patient require greater than 21% oxygen for at least 28 days after birth? ☐ Yes ☐ No

(if age 12 months to less than 24 months) Has the patient required medical therapy (that is, supplemental oxygen, diuretic therapy, or chronic corticosteroid therapy) during the 6 months before the start of the second RSV season? ☐ Yes ☐ No

if congenital heart disease

Will the patient be or is the patient LESS THAN 12 months of age at the start of the RSV season? ☐ Yes ☐ No

Is the medication prescribed by, or in consultation with, a cardiologist or intensivist? ☐ Yes ☐ No

According to the prescriber, is the patient considered to have hemodynamically significant cyanotic congenital heart disease? ☐ Yes ☐ No

(if no) According to the prescriber, does the patient have moderate to severe pulmonary hypertension? ☐ Yes ☐ No

(if no) According to the prescriber, does the patient have lesions adequately corrected by surgery? ☐ Yes ☐ No

(if yes) According to the prescriber, does the patient continue to require medication for their congestive heart failure? ☐ Yes ☐ No

(if no) According to the prescriber, does the patient have acyanotic heart disease? ☐ Yes ☐ No

(if yes) According to the prescriber, is the patient receiving medication to control heart failure? ☐ Yes ☐ No

(if yes) According to the prescriber, will the patient require cardiac surgical procedures? ☐ Yes ☐ No

if premature birth

Was this patient born prematurely (defined as 28 weeks 6 days gestation or less)? ☐ Yes ☐ No

Will the patient be or is the patient LESS THAN 12 months of age at the start of the RSV season? ☐ Yes ☐ No

if anatomic pulmonary abnormalities or a neuromuscular disorder

Will the patient be or is the patient LESS THAN 12 months of age at the start of the RSV season? ☐ Yes ☐ No

According to the prescriber, is the patient's condition compromising the handling of respiratory secretions? ☐ Yes ☐ No

if immunocompromised

According to the prescriber, is the patient or will the patient be profoundly immunocompromised during the RSV season? ☐ Yes ☐ No

Is the medication prescribed by, or in consultation with, an immunologist or an infectious disease specialist? ☐ Yes ☐ No

Will the patient be or is the patient less than 24 months of age at the start of RSV season? ☐ Yes ☐ No

if cardiac transplant

Has/Will the patient undergone/undergo a cardiac transplantation during the current RSV season? ☐ Yes ☐ No

Is the requested medication prescribed by, or in consultation with, a cardiologist, intensivist, or transplant physician? ☐ Yes ☐ No

Will the patient be or is the patient less than 24 months of age at the start of RSV season? ☐ Yes ☐ No

Additional pertinent information:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:________________________________ **Date:**______________

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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