BlueCross BlueShield of North Carolina

# Respiratory Syncytial Virus Prophylaxis palivizumab (Synagis®)

INTRAMUSCULAR INJECTION FOR ADMINISTRATION BY A HEALTHCARE PROFESSIONAL

**PRIOR REVIEW/CERTIFICATION REQUEST FOR SERVICES FORM**

**INCOMPLETE FORMS MAY DELAY PROCESSING**

**ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT Blue Cross NC PROVIDER ID# BELOW**

| PATIENT NAME | BLUE CROSS NC MEMBER ID NUMBER | PATIENT DATE OF BIRTH |
|---|---|---|
| | | |

| REQUESTING PROVIDER INFORMATION | | SERVICING PROVIDER OR FACILITY LOCATION (for services to be performed outside of the physician office) | |
|---|---|---|---|
| **Provider Name** | | **Servicing Provider** | |
| **Provider #, Tax ID # or NPI** | | **Facility Name** | |
| **Street, Bldg., Suite #** | | **Servicing provider or Facility #, Tax ID # or NPI** | |
| **City/State/Zip code** | | **Street, Bldg., Suite #** | |
| **Phone #** | | **City/State/Zip code** | |
| **Fax #** | | | |
| **PLACE OF SERVICE:** ☐ Home ☐ Office ☐ Outpatient hospital ☐ Specialty Pharmacy | | | |
| **Specialty Pharmacy:** | | **Specialty Pharmacy NPI:** | |
| **HCPCS CODE:** ☐ 90378 | | **CPT/Other billing code:** | |
| **Primary Diagnosis:** | | **ICD-10:** | |

**Please answer the following questions:**

1. Will the patient be receiving monthly administration of the requested medication for immune prophylaxis for respiratory syncytial virus (RSV)?..... ☐ Yes ☐ No
2. Will the patient be receiving the requested medication during the RSV season?..... ☐ Yes ☐ No
3. Will the patient receive the requested medication in accordance with guideline-based recommendations?..... ☐ Yes ☐ No
4. Is the patient an infant/child (≤ 24 months of age at the start of therapy)?..... ☐ Yes ☐ No

   **If YES, please answer the following questions and submit medical record documentation:**

   a. Will the patient be profoundly immunocompromised (e.g., will undergo solid organ or hematopoietic stem cell transplantation or receive chemotherapy) during RSV season?..... ☐ Yes ☐ No
   b. Has the patient had a surgical procedure that used cardiopulmonary bypass?..... ☐ Yes ☐ No

      **If YES, please answer the following questions:**

      i. Will the requested medication be administered after cardiac bypass?..... ☐ Yes ☐ No
      ii. Will the requested medication be administered at the conclusion of extracorporeal membrane oxygenation?..... ☐ Yes ☐ No

****continued on page 2; sign page 3 for prior authorization****

# Respiratory Syncytial Virus Prophylaxis: palivizumab (Synagis®) - *continued*

5. Is the patient in the first year of life (i.e., younger than 12 months at the start of the RSV season or born during the RSV season)?..... ☐ Yes ☐ No
   **If YES, please answer the following questions and submit medical record documentation:**
   a. Was the patient born before 29 weeks, 0 days gestation?..... ☐ Yes ☐ No
   b. Was the patient a preterm infant with chronic lung disease (CLD) of prematurity, defined as birth at less than 32 weeks, 0 days gestation and a requirement for more than 21% oxygen for at least the first 28 days after birth?..... ☐ Yes ☐ No
   c. Does the patient have hemodynamically significant heart disease (e.g., acyanotic heart disease, receiving medication to control congestive heart failure, and requiring cardiac surgical procedures; moderate to severe pulmonary hypertension; lesions adequately corrected by surgery, but continue to require medication for heart failure)?..... ☐ Yes ☐ No
      i. **If YES**, does the patient have cyanotic heart defects?..... ☐ Yes ☐ No
         1. **If YES,** will decisions regarding prophylactic treatment with the requested medication be made by or in consultation with a pediatric cardiologist?..... ☐ Yes ☐ No
   d. Does the patient have pulmonary abnormalities or neuromuscular disease that impairs the ability to clear secretions from the upper airways (e.g., ineffective cough, recurrent gastroesophageal tract reflux, pulmonary malformations, tracheoesophageal fistula, upper airway conditions, or conditions requiring tracheostomy)?..... ☐ Yes ☐ No
   e. Has the patient been diagnosed with cystic fibrosis?..... ☐ Yes ☐ No
      **If YES, please answer the following questions:**
      i. Does the patient have clinical evidence of CLD?..... ☐ Yes ☐ No
      ii. Does the patient have nutritional compromise?..... ☐ Yes ☐ No

6. Is the patient in the second year of life (i.e., older than 12 months, but younger than 24 months at the start of the RSV season)?..... ☐ Yes ☐ No
   **If YES, please answer the following questions and submit medical record documentation:**
   a. Was the patient born at less than 32 weeks, 0 days gestation and required at least 28 days of supplemental oxygen after birth?..... ☐ Yes ☐ No
      i. **If YES,** does the patient continue to require medical intervention (e.g., supplemental oxygen, chronic corticosteroid, or diuretic therapy) during the 6-month period before the start of the second RSV season?..... ☐ Yes ☐ No
   b. Does the patient have a diagnosis of cystic fibrosis?..... ☐ Yes ☐ No
      **If YES, please answer the following questions:**
      i. Does the patient have manifestations of severe lung disease (i.e., previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest radiography or chest computed tomography that persist when stable)?..... ☐ Yes ☐ No
      ii. Does the patient have weight for length less than the 10$^{th}$ percentile?..... ☐ Yes ☐ No

****continued on page 3; sign page 3 for prior authorization****

# Respiratory Syncytial Virus Prophylaxis: palivizumab (Synagis®) - *continued*

7. Does the patient have any of the following:
   a. Hemodynamically insignificant heart disease (e.g., secundum atria septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus)?..... ☐ Yes ☐ No
   b. Lesions that are adequately corrected by surgery?..... ☐ Yes ☐ No
      i. **If YES,** does the patient continue to require medication for heart failure?..... ☐ Yes ☐ No
   c. Mild cardiomyopathy?..... ☐ Yes ☐ No
      i. **If YES,** is the patient receiving medical therapy for the condition?..... ☐ Yes ☐ No
   d. Congenital heart disease in the second year of life?..... ☐ Yes ☐ No

8. Is the requested quantity within the maximum visits allowed (see table below)?..... ☐ Yes ☐ No
   **If NO, please complete page 4 for a quantity limit exception.**

**Please certify the following by signing and dating below:**
I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in my patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available.
**Prescriber's Signature (Required)**:_____ **Date**:_____

***For Blue Cross NC members, fax form to 1-888-348-7332***

| FDA Label Reference | | | | |
|---|---|---|---|---|
| **Medication** | **Indication** | **Dosing** | **HCPCS** | **Maximum Units*** |
| palivizumab (Synagis®)<br><br>intramuscular (IM) injection | RSV prophylaxis in patients ≤ 24 months old at start of dosing | IM: 15 mg/kg given prior to start of RSV season and remaining doses given monthly throughout RSV season; up to a maximum of 5 monthly doses during the RSV season.<br><br>If undergoing cardio-pulmonary bypass, additional dose should be given as soon as possible after procedure, then given monthly as scheduled. | 90378 | 5 visits (6 units max) |

***Maximum units allowed for duration of approval**

BlueCross BlueShield of North Carolina

# Respiratory Syncytial Virus Prophylaxis – QUANTITY LIMIT EXCEPTION
# palivizumab (Synagis®)

INTRAMUSCULAR INJECTION FOR ADMINISTRATION BY A HEALTHCARE PROFESSIONAL

| PATIENT NAME | BLUE CROSS NC MEMBER ID NUMBER | PATIENT DATE OF BIRTH |
|---|---|---|
| | | |

| REQUESTING PROVIDER INFORMATION | | SERVICING PROVIDER OR FACILITY LOCATION (for services to be performed outside of the physician office) | |
|---|---|---|---|
| **Provider Name** | | **Servicing Provider** | |
| **Provider #, Tax ID # or NPI** | | **Facility Name** | |
| **Street, Bldg., Suite #** | | **Servicing provider or Facility #, Tax ID # or NPI** | |
| **City/State/Zip code** | | **Street, Bldg., Suite #** | |
| **Phone #** | | **City/State/Zip code** | |
| **Fax #** | | | |

**PLACE OF SERVICE:** ☐ Home ☐ Office ☐ Outpatient hospital ☐ Specialty Pharmacy

| | |
|---|---|
| **Specialty Pharmacy:** | **Specialty Pharmacy NPI:** |
| **HCPCS CODE:** ☐ 90378 | **CPT/Other billing code:** |
| **Primary Diagnosis:** | **ICD-10:** |
| **Drug Requested:** | |
| **Strength & Route of Administration:** | |

**FOR COVERAGE OVER THE FDA LABELED DOSING (SEE TABLE ON PAGE 3), PLEASE ANSWER THE FOLLOWING:**

*Please note: This medication requires a prior authorization before a quantity limit override can be considered. Before submitting a request for a quantity level override, please ensure that a prior approval authorization has been submitted and/or approved (pages 1-3). Otherwise, this request will deny.*

**Requested units: _____ Requested visits: _____**

***Please enter quantity as a numeric value with one decimal place (ex. 1.0, 1.5)****

**In the space provided, please document** support for the requested Quantity Limit Exception (this may include documented clinical rationale and/or medical records).

_____

_____

_____

**Please certify the following by signing and dating below:**

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in my patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available.

**Prescriber's Signature (Required)**:_____ **Date**:_____

***For Blue Cross NC members, fax form to 1-888-348-7332***