

## Respiratory Syncytial Virus Enrollment Form

Date: [date]      Attention: <input type="checkbox"/> Patient <input type="checkbox"/> Office <input type="checkbox"/> Other:		
Please complete and fax back to <b>1-888-209-7838</b> no later than [date].		
<b>Section 1 — member and provider information</b>		
Last name:	First name:	Middle initial:
Member ID number:	Date of birth:	
Member address (Street, city, state, ZIP+4)		
Name of prescriber:	Prescriber NPI:	
Prescriber address (Street, city, state, ZIP+4)		
Prescriber telephone number:		
Billing provider name:	Billing provider NPI number:	
<b>Section II — clinical information for all prior authorization (PA) requests</b>		
Was Synagis <sup>®</sup> administered when the child was hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, indicate the date(s) of administration in the space(s) provided. (No more than five doses will be authorized, inclusive of any hospital-administered doses.)		
1.	2.	3.
Child's current weight (in kilograms)	Date child weighed	
Calculated dosage of Synagis (15 milligrams per kilogram of body weight)		
Case-specific diagnosis/ICD-10		
Providers are required to complete <i>one</i> of Section III A, III B, III C, III D, III E or III F (depending on the child's medical condition) for a PA request to be considered for approval.		
<b>Section III A — clinical information for chronic lung disease</b>		
The child has chronic lung disease of prematurity.		<input type="checkbox"/> Yes <input type="checkbox"/> No
Did the child require oxygen at greater than 21% for at least the first 28 days after birth?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Indicate the child's gestational age at delivery (in weeks and days).		
Weeks _____ Days _____		
Check all therapies below that the child has continuously used over the past six months.		
<input type="checkbox"/> Corticosteroid <input type="checkbox"/> Diuretic <input type="checkbox"/> Supplemental oxygen		

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**Section III B — clinical information for congenital heart disease**

The child is younger than 12 months of age at the start of the respiratory syncytial virus (RSV) season and has hemodynamically significant congenital heart disease.  Yes  No

**Section III C — clinical information for cardiac transplant**

The child is younger than 24 months of age at the start of the RSV season and is scheduled to undergo a cardiac transplantation during the RSV season.  Yes  No

**Section III D — clinical information for preterm infants**

The child is younger than 12 months of age at the start of the RSV season and was born before 29 weeks of gestation, in other words, zero days through 28 weeks, six days.  Yes  No

Indicate the child's gestational age at delivery (in weeks and days).

Weeks \_\_\_\_\_ Days \_\_\_\_\_

**Section III E — clinical information for pulmonary abnormalities and neuromuscular disease**

The child is younger than 12 months of age at the start of the RSV season and has a neuromuscular disease or congenital abnormality that impairs the ability to clear secretions from the upper airway because of an ineffective cough.  Yes  No

If yes, indicate the disease or anomaly.

**Section III F — clinical information for immunocompromised children**

The child is younger than 24 months of age at the start of the RSV season and is profoundly immunocompromised due to the following:

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| a. Solid organ transplant              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Stem cell transplant                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Receiving chemotherapy              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Acquired Immune Deficiency Syndrome | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Other                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If other, indicate the cause of the child's immunodeficiency.

**Section IV — authorized signature**

Prescriber signature

Date signed

**Section V — additional information**

Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may be included here.