Palivizumab (Synagis®) Injectable Medication Precertification Request

(All fields must be completed and legible for Precertification Review)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____ ☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: ______________________ Phone: ____________ Fax: ____________

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	E-mail:

Current Weight: ______ lbs or ______ kgs Height: ______ inches or ______ cms | Allergies:

B. INSURANCE INFORMATION

Aetna Member ID #: ______________________
Group #: ______________________
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: ____________ Carrier Name: ____________
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider E-mail:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ Primary Care (Pediatrician) ☐ Other:

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Physician's Office
☐ Outpatient Infusion Center Phone: ______________
Center Name: ______________________
☐ Home Infusion Center Phone: ______________
Agency Name: ______________________
☐ Administration code(s) (CPT): ______________

Dispensing Provider/Pharmacy: *(Patient selected choice)*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: ______________
Name: ______________________
Phone: ______________ Fax: ______________
TIN: ______________ PIN: ______________

E. PRODUCT INFORMATION

Request is for Synagis®: ☐ 15mg/kg IM one time per month (every 30 days) ☐ Other: ______________

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD code: ______________ Secondary ICD code: ______________ Other ICDCode: ______________

G. CLINICAL INFORMATION - Required clinical information must be completed in its <u>entirety</u> for all precertification requests.

Gestational Age at Birth (*weeks*) ______ **(*days*)** ______

☐ Yes ☐ No Was a NICU dose administered? ***If yes, date received:*** ____/____/____
☐ Yes ☐ No Is the child less than 1 year of age?
☐ Yes ☐ No Is the child over 2 years of age?
☐ Yes ☐ No Did the child receive dosing during the previous RSV season?
☐ Yes ☐ No Is this a request for an additional dose (Pre or Post RSV season)?

Chronic Lung Disease of Prematurity:

☐ Yes ☐ No Does the infant have chronic lung disease of prematurity (formerly known as broncho-pulmonary dysplasia or BPD)?
☐ Yes ☐ No Did the child require greater than 21% oxygen for at least 28 days after birth?
☐ Yes ☐ No Does the child continue to require medical intervention (supplemental oxygen, chronic corticosteroid or diuretic therapy) during the 6 month period before the start of the RSV season?
List the medical therapies: ______________________

Congenital Heart Disease:

☐ Yes ☐ No Does the infant have hemodynamically significant congenital heart disease?
If yes, please answer the following questions:
- ☐ Yes ☐ No Does the infant have cyanotic heart disease? (including Tetralogy of Fallot, transposition of the great vessels, Ebstein's anomaly, tricuspid atresia, total anomalous pulmonary venous return, truncus arteriosus, and hypoplastic left heart syndrome)?
- ☐ Yes ☐ No Does the infant have moderate to severe pulmonary hypertension?
- ☐ Yes ☐ No Does the infant have acyanotic heart disease?
- ☐ Yes ☐ No Is the infant receiving medication to control their congestive heart failure?
Please list meds: ______________________
- ☐ Yes ☐ No Does the infant require cardiac surgical procedures?

☐ Yes ☐ No Does the infant have hemodynamically insignificant heart disease? (e.g., secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus)
☐ Yes ☐ No Does the infant have lesions adequately corrected by surgery who do not require medication for congestive heart failure?
☐ Yes ☐ No Does the infant have mild cardiomyopathy and is not on medications for the condition?
☐ Yes ☐ No Has the child had a cardiac transplant during the RSV season?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(Continued)*

Anatomic Pulmonary Abnormalities or Neuromuscular Disorders:

☐ Yes ☐ No Does the child have Anatomic Pulmonary Abnormalities or Neuromuscular Disorders impairing the ability to clear secretions from the upper airways because of an ineffective cough?

Cystic Fibrosis:

☐ Yes ☐ No Does the child have Cystic Fibrosis?

If yes, please answer the following questions:

- ☐ Yes ☐ No Does the child have clinical evidence of CLD?
- ☐ Yes ☐ No Does the child have nutritional compromise?
- ☐ Yes ☐ No Was the child previously hospitalized for pulmonary exacerbations in the first year of life?
- ☐ Yes ☐ No Does the child have abnormalities on chest radiography (x-ray) or chest computed tomography (ct scan) that persist when stable?
- ☐ Yes ☐ No Is the child's weight for length less than the 10th percentile?

Immunocompromised patients:

☐ Yes ☐ No Will the child be profoundly immunocompromised during the RSV season?

If yes, please indicate which of the following applies:

- ☐ Yes ☐ No Does the child have severe combined immunodeficiency syndrome?
- ☐ Yes ☐ No Does the child have severe acquired immunodeficiency syndrome?
- ☐ Yes ☐ No Does the child have acute myeloid leukemia/acute lymphoblastic leukemia?
- ☐ Yes ☐ No Is the child a hematopoietic stem cell transplant recipient?
- ☐ Other – Please specify: ______________________________

Other considerations:

☐ Yes ☐ No Is the infant an Alaskan native or among the American Indian population?

If yes, please describe specific considerations: ______________________________

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required)*: ______________________________ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.