Synagis® (palivizumab) Injectable Medication Precertification Request

(All fields must be completed and legible for precertification review)

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

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): _____
Address: _____

Dispensing Provider/Pharmacy: *(Patient selected choice)*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: _____
Name: _____
Address: _____
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 entirety for all precertification requests.

For ALL requests (clinical documentation must be submitted):
Gestational Age at Birth (*weeks*) _____ **(*days*)** _____

☐ Yes ☐ No Is the requested drug being used to prevent serious lower respiratory tract disease caused by RSV?
☐ Yes ☐ No Does the patient have a diagnosis of prematurity (defined as gestational age ≤ 28 weeks, 6 days)?
☐ Yes ☐ No Is this an off-season request for the requested drug?
☐ Yes ☐ No 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 How many doses of the requested drug has the patient received this RSV season? _____

Chronic Lung Disease of Prematurity:
What was the patient's gestational age? ☐ ≤31 weeks, 6 days ☐ ≥32 weeks, 0 days
What is the patient's chronological age at the start of RSV season? ☐ <12 months of age
→ ☐ Yes ☐ No Did the patient receive the requested drug during the previous RSV season?
☐ 12 to <24 months of age
☐ ≥24 months of age

☐ Yes ☐ No Does/Did the child require greater than 21% oxygen for at least the first 28 days after birth?
☐ Yes ☐ No Does the child continue to require medical support during the 6 month period prior to the start of the RSV season?
→ ***Please indicate the medical therapy:*** ☐ Oxygen ☐ Diuretic ☐ Chronic corticosteroid ☐ Other, please explain: _____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(Continued)*

Congenital Heart Disease:

☐ Yes ☐ No Does the patient have hemodynamically significant congenital heart disease?

What is the patient's chronological age at the start of RSV season?
- ☐ <12 months of age
- ☐ 12 to <24 months of age
  - → ☐ Yes ☐ No Is there a possibility that the patient will be undergoing cardiac transplantation during RSV season?
- ☐ ≥24 months of age

Congenital Abnormalities of the Airway or Neuromuscular Disorders:

☐ Yes ☐ No Does the patient's condition compromise handling of respiratory secretions?

What is the patient's chronological age at the start of RSV season?
- ☐ <12 months of age
- ☐ ≥12 months of age

Cystic Fibrosis:

What is the patient's chronological age at the start of RSV season?
- ☐ <12 months of age
  - → ☐ Yes ☐ No Does the child have evidence of chronic lung disease (CLD) or nutritional compromise?
- ☐ Between 12 and 24 months of age
  - → ☐ Yes ☐ No Does the patient have manifestations of lung disease (e.g., hospitalizations for pulmonary exacerbations) or weight for length less than the 10th percentile?
- ☐ ≥24 months of age

Immunocompromised patients:

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

What is the patient's chronological age at the start of RSV season?
- ☐ <24 months of age
- ☐ ≥24 months of age

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.