CVS CAREMARK

Fax Referral To: 800-323-2445

Phone: 866-278-6634

Synagis® (palivizumab)
Enrollment Form
For Blue Cross Blue Shield of Rhode Island Members

Date: _____ **Needs by Date (Please Specify):** _____

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** _____

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS #: _____
Insurance ID: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____
Contact Phone: _____

INSURANCE INFORMATION (*Please copy and attach the front and back of insurance and prescription drug card)*

Prescription Card:	Name of Insurer:		ID#:		BIN:		PCN:		Group:
Primary Insurance:	Subscriber:		ID#:		Name of Insurer:	**Blue Cross Blue Shield of RI**		Phone:	
Secondary Insurance:	Subscriber:		ID#:		Name of Insurer:			Phone:	

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis (ICD-9 Code): ☐ _____ • Date of Diagnosis: _____

Approval Criteria: CHECK ALL BOXES THAT APPLY

Please note: Any areas that are not filled out will be considered not applicable to your patient AND MAY AFFECT THE OUTCOME OF THIS REQUEST

- What is the patient's weight? _____
- Was the patient born prematurely? ☐ Yes ☐ No
  - If yes, please indicate the gestational age of the infant: _____
- Patient has chronic lung disease (CLD) [formerly designated Bronchopulmonary Dysplasi (BPD)] ☐ Yes ☐ No
  - Patient has required medical treatment within six months before the start of RSV season with oxygen, steroids, bronchodilators or diuretics. ☐ Yes ☐ No
- Patient has hemodynamically significant (for example, but not limited to, receiving medication for congestive heart failure or moderate to severe pulmonary hypertension) cyanotic or acyanotic congenital heart disease (CHD). ☐ Yes ☐ No
- Patient was born before 35 weeks of gestation and has congenital abnormalities of the airway or neuromuscular disease with congenital abnormalities of the airway, or a neuromuscular condition that compromises handling of respiratory secretions. ☐ Yes ☐ No
- Are there currently any risk factors present? If yes, please select any that apply: ☐ Yes ☐ No
  - ☐ Patient lives with other children who are less than 5 years of age.
  - ☐ Patient attends group child care.
  - ☐ Other: _____
- Patient is in an approved course of treatment, has undergone cardiopulmonary bypass for surgical procedures, and has documented reduction in serum levels post-bypass.
  - ☐ Yes ☐ No If yes, please indicate the date of the procedure: _____
- Patient is receiving RSV immunoprophylaxis and is experiencing break-through RSV infection. ☐ Yes ☐ No

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Synagis® (palivizumab)			**(per 30 days)**	

X _____
PRODUCT SUBSTITUTION PERMITTED (Date)

X _____
DISPENSE AS WRITTEN (Date)