Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Synagis
(palivizumab)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:		* Date of Birth:
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone Number:		

PRESCRIPTION INFORMATION

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

SYNAGIS® (Palivizumab C9003): ☐Inject 15 mg/kg IM once monthly	Refills (months): ☐Through March of current RSV season ☐Other:	EXPECTED DATE OF INJECTION (MM/DD/YY) *Required to ensure accurate dispensing:*
☐Other:	Qty: 1 Refill: ☐Other:	

Please note type of Auth Request

☐ Pre-Season: *If you are requesting pre-season dosing for your locale, please provide justification necessitating early administration and include supporting data from the CDC or local health department supporting an early start date to Synagis season.*

☐ Current Season: *RSV season begins in November and ends in March for most of the US. If you are requesting in-season dosing outside of these months, please provide justification.*

☐ Post Season: *Please include virology data from the CDC if additional doses are needed.*

Where will this medication be obtained?

☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):
Is this infusion occurring in a facility affiliated with hospital outpatient setting? Yes ☐ No ☐
If yes- Is this patient a candidate for re-direction to an alternate setting after 1-2 infusions (such as AIS, MDO, home) with assistance of a Specialty Care Option Case Manager? Yes ☐ No ☐
NOTE: Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting.

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Which of the following uses applies to your patient? ICD10:
☐ prophylaxis of RSV in an inpatient environment
☐ prophylaxis of RSV in an outpatient environment
☐ treatment of RSV

☐ none of the above

****This drug requires supportive documentation (i.e. chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request****

Clinical Data:

Infant / child's Weight: _____ Date recorded: _____

Gestational age at birth: _____ weeks _____ days

Please provide anticipated month of start of RSV season in patient's residence area:

Please specify the number of injections you are requesting:

What is the start date of therapy? What is the end date of therapy?

Please note: *If you are requesting pre-season dosing for your locale, please provide justification necessitating early administration and include supporting data from the CDC or local health department supporting an early start date to Synagis season.*

**Typically, RSV season begins in November and ends in March. However, the duration of the Synagis season remains 5 consecutive months for all geographic areas in the United States.

Is your patient's race or origin one of the following?

☐ American Indian ☐ Alaska Native ☐ neither

Does your patient have any of the following conditions? (Please check all that apply to your patient):

- ☐ chronic lung disease (CLD)
- ☐ cystic fibrosis (CF)
- ☐ prematurity
- ☐ congenital heart disease (CHD)
- ☐ cardiac transplantation
- ☐ severe immunodeficiency
- ☐ congenital abnormalities of the airway or neuromuscular disease

☐ none of the above

For patients with Chronic Lung Disease:

Did your patient require supplemental oxygen for at least the first 28 days after birth? ☐ Yes ☐ No

Has your patient required any of the following medical care for their BPD within the last 6 months?
(Please check all that apply to your patient):

- ☐ Supplemental oxygen Date of last use
- ☐ Treatment with a diuretic date of last use
- ☐ Treatment with a corticosteroid date of last use

For patients with Cystic Fibrosis:

Did your patient require supplemental oxygen for at least the first 28 days after birth? ☐ Yes ☐ No

Is your patient's weight for length less than the 10th percentile on a pediatric growth chart? ☐ Yes ☐ No

(if no and age 12-24 mos) Is your patient exhibiting symptoms of severe lung disease? ☐ Yes ☐ No
(include history of hospitalization for pulmonary exacerbation and chest x-ray or CT scan)

For patients with Congenital Heart Disease:

Does your patient have hemodynamically significant heart disease? ☐ Yes ☐ No

Do any of the following conditions apply to this patient? (Please check all that apply to your patient):

- ☐ acyanotic CHD and receiving treatment for congestive heart failure (CHF)
- ☐ moderate to severe pulmonary hypertension (PH, PAH)
- ☐ cyanotic CHD and recommended by a pediatric cariologist
- ☐ none of the above or unknown

(if acyanotic CHD) Will your patient require cardiac surgery? ☐ Yes ☐ No

Has your patient undergone or will they undergo cardiac bypass or ECMO (extracorporeal membrane oxygenation)? ☐ Yes ☐ No

Congenital Abnormalities of the Airway or Neuromuscular disease

What is the diagnosis? _____

Does this condition compromise the handling of respiratory secretions? ☐ Yes ☐ No

For patients with severe immunodeficiency:

What is the specific diagnosis related to immunodeficiency?

Additional pertinent information:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

v081518

Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005