

**REVIEW REQUEST FOR  
Synagis® (palivizumab)**

**Complete form in its entirety and fax to: Anthem Blue Cross 866-408-7195**

**Provider Data Collection Tool Based on Medical Policy DRUG.00015**



Policy Last Review Date: 08/18/11	Policy Effective Date: 08/22/2011	Provider Tool Effective Date: 08/22/2011
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Request Date:        /        /		
<input type="checkbox"/> <b>Initial Request</b> <span style="margin-left: 200px;"><input type="checkbox"/> <b>Subsequent Request</b></span>		
<input type="checkbox"/> <b>Buy and bill</b>		
Individual's Name:		Date of Birth: /      /
Insurance Identification Number:		Individual's Phone Number:
Primary Diagnosis:	ICD-9 Code(s) (if known):	Individual's Weight _____ <input type="checkbox"/> (lbs) <input type="checkbox"/> (kg)
Ordering Provider Name & Specialty:		Provider Tax ID or NPI Number:
Office Address:		
Contact Name and Office Phone Number:		Office Fax Number:
Servicing Provider Name & Specialty (If different than Ordering Provider):		Provider Tax ID or NPI Number:
Office Address:		
Contact Name and Office Phone Number:		Office Fax Number:
Place of Service: <input type="checkbox"/> Home <input type="checkbox"/> Office <input type="checkbox"/> Dialysis Center <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Ambulatory Infusion <input type="checkbox"/> Ambulatory Infusion Center <input type="checkbox"/> Other: _____		
Drug Name/HCPS Code (if known) Synagis® <input type="checkbox"/> 90378 Other: _____	Dose to be administered: _____ (units)	
When did the individual first start this drug? /      /	Frequency (Days, Wks, Months) _____	
Duration: _____ (Weeks)	Start Date For This Request: /      /	

**Please check all that apply to the individual:**

**(1) Prevention of Respiratory Syncytial Virus (RSV)**

**Please list individual's current age:** \_\_\_\_\_

**Please list individual's gestational age:** \_\_\_\_\_

- Request is for up to three (3) doses of palivizumab (Synagis®) during one RSV season in the first year of life
  - Infant born between 32 and 35 weeks gestation,\* (beginning 32 weeks, 0 days through 34 weeks, 6 days)
  - Less than 3 months of age at the start of the RSV season
  - Less than 90 days old at the time of dosing
  - Attends group child care (defined as a home or facility where care is provided along with at least one other infant or young child) or there are siblings or other children living in the household who are less than 5 years of age
  - Other: \_\_\_\_\_

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- Request is for five (5) doses of palivizumab (Synagis<sup>®</sup>) within the RSV season during the first year of life
- Born at 28, or less, weeks of gestation (up to and including 28 weeks, 6 days) and less than 12 months of age at the start of the RSV season
  - Born at 29 to 32 weeks gestation (beginning 29 weeks, 0 days through 31 weeks, 6 days) and less than 6 months of age at the start of the RSV season
  - Individual has chronic lung disease (CLD) [formerly designated Bronchopulmonary Dysplasia (BPD)]
    - The lung disease is **NOT** asthma, reactive airway disease or cystic fibrosis
    - Individual has required medical treatment within six months before the start of the RSV season with oxygen, steroids, bronchodilators or diuretics
    - Other: \_\_\_\_\_
  - Individual 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)
  - Individual has congenital abnormalities of the airway or a neuromuscular condition that compromises the handling of respiratory secretions
  - Other: \_\_\_\_\_
- Request is for five (5) doses of palivizumab (Synagis<sup>®</sup>) within the RSV season during the second year of life
- Individual has chronic lung disease (CLD) [formerly designated Bronchopulmonary Dysplasia (BPD)]
    - The lung disease is **NOT** asthma, reactive airway disease or cystic fibrosis
    - Individual has required medical treatment within six months before the start of the RSV season with oxygen, steroids, bronchodilators or diuretics
    - Other: \_\_\_\_\_
  - Individual 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)
  - Individual has congenital abnormalities of the airway or a neuromuscular condition that compromises the handling of respiratory secretions
  - Other: \_\_\_\_\_
- Request is for an additional dose of palivizumab (Synagis<sup>®</sup>) for a child in an approved course of treatment who undergo cardiopulmonary bypass for surgical procedures due to documented reduction in serum levels post-bypass

**(2) Other Use(s)** (Please submit all supporting documents including labs, progress notes, imaging, etc., for review.)

This request is being submitted:

- Pre-Claim
- Post-Claim. If checked, please attach the claim or indicate the claim number \_\_\_\_\_

I attest the information provided is true and accurate to the best of my knowledge. I understand that the health plan or its designees may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

\_\_\_\_\_  
Name and Title of Provider or Provider Representative Completing Form and Attestation (Please Print)\*

\_\_\_\_\_  
Date

**\*The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted**