



Fax: 866-391-1890
Phone: 888-293-9309

RSV/Synagis Enrollment/Prescription Form

Please complete this form for members needing a Synagis prescription and fax it to BriovaRx at 866-391-1890. BriovaRx, a network specialty pharmacy, will notify you and your patient of prescription coverage. This form helps determine if the patient's condition meets drug policy guidelines, so please fill it out completely. Any missing information may cause a delay in the coverage decision. If you have questions or need to request a refill, please contact BriovaRx at 888-293-9309.

For all REFILL requests, please call 888-293-9309

PATIENT INFORMATION (Section must be completed to process prescription)

Patient Name _____ DOB _____ Gender: M F
 Parent/Guardian _____ Last Four of SS# _____ Home Phone _____
 Address _____ Alternate Phone _____
 City _____ State & ZIP _____ Language Preference: English Spanish Other _____

INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides)

Prior Authorization Reference number _____

PHYSICIAN INFORMATION AND PRESCRIPTION FOR SYNAGIS

Referring Physician _____ NPI # _____
 Practice Name _____ DEA # _____
 Address _____ Phone # _____
 Medicaid Prescriber # _____ Office Contact _____ Fax # _____

NEXT injection OR FIRST injection due. Date _____ Has first dose been given? Yes No If Yes, When? _____ Where? _____

Subsequent injections will be administered in: Hospital MD Office Patient's Home Other _____

Check here to have us coordinate nursing for in-home injections. (service available in select regions)

Preferred home health agency, if any _____ Already in the home? _____

PRESCRIPTION INFORMATION

Medication	Strength	Directions	Quantity	Total Doses Requested
<input type="checkbox"/> Rx Synagis®	50 and/or 100mg vials	Inject 15mg/kg IM one time per month	Other: QS to achieve 15mg/kg dose	
<input type="checkbox"/> Rx Epinephrine	1:1000 amp	Inject 0.01 mg/kg subcutaneously as directed for anaphylaxis	QS	

Previous injections (including doses given in hospital): Yes No If Yes, dates: _____

Which months are requested for the current season? (Circle) Nov. Dec. Jan. Feb. Mar. Other (specify) _____

Specialty pharmacy to coordinate injection training/home health nurse visit as necessary Yes No

Allergies: Yes No If Yes, please list: _____

Other medical history: _____

Has the child been previously approved for Synagis by another insurance carrier for the current season? Yes No

(Please attach approval from previous insurance carrier and clinical notes for doses already given)

*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to: Patient Office Other _____ Date _____ Needs by Date _____

Product Substitution permitted Dispense as Written

Prescriber's Signature _____ Date _____ Supervising physician _____ Date _____

MEDICAL INFORMATION

ICD-10 Code: _____ Diagnosis: _____

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List Meds and Dates _____ Ventilator and Dates _____

CLINICAL INFORMATION

Patient's Gestational Age (Required): _____ Weeks _____ Days

Patient is a multiple birth: No Yes

• Current weight in: _____ kilograms (kg) _____ pounds (lbs) Date recorded: _____

Chronic lung disease (CLD): No Yes ICD-10 Code: _____ (attach medical history)

• Require more than 21% oxygen at least 28 days after birth: No Yes

• Therapy received within 6 months start of RSV season (check all that apply):

Supplemental oxygen: Last date _____

Chronic systemic corticosteroid therapy: Last date _____ Drug name _____

Diuretics therapy: Last date _____ Drug name _____

Congenital heart disease (CHD): No Yes ICD-10 Code: _____ (attach medical history)

• Acyanotic heart disease: No Yes

• Cyanotic heart disease: No Yes

• Moderate to severe pulmonary hypertension: No Yes

• Requires cardiac surgical procedure: No Yes

• In consultation with pediatric cardiologist during first year of life: No Yes

• List cardiac medications:

_____ Last date received: _____

_____ Last date received: _____

_____ Last date received: _____

Compromised handling of respiratory secretions: No Yes ICD-10 Code: _____ (attach medical history)

Congenital abnormality of the lower airway: No Yes ICD-10 Code: _____ (attach medical history)

Neuromuscular condition: No Yes ICD-10 Code: _____ (attach medical history)

Receiving chemotherapy: No Yes ICD-10 Code: _____ (attach medical history)

Cystic Fibrosis: No Yes ICD-10 Code: _____ (attach medical history)

• Prior hospitalization for pulmonary exacerbation in first year of life: No Yes (attach medical history)

• Abnormal chest radiography or chest computer tomography that persists when stable: No Yes