

**1. PHARMACY INFORMATION**

**Elixir Specialty Pharmacy**

Phone: 877.437.9013

Fax: 877.309.0687

**2. CUSTOMER INFORMATION** (Please print or type clearly)

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Numbers (Include Area Code): Day \_\_\_\_\_

Night \_\_\_\_\_ Cell Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_  Male  Female

Allergies \_\_\_\_\_

Primary Caregiver \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

**INSURANCE INFORMATION** (Include copies of insurance card - front and back):

Primary Insurance \_\_\_\_\_ Phone \_\_\_\_\_

Name of Cardholder \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

**DELIVERY INSTRUCTIONS:**

Physician  Other \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**3. PRESCRIBER INFORMATION** \*Indicates Required Field

Prescriber (First & Last)\* \_\_\_\_\_

NPI #\* \_\_\_\_\_ DEA # \_\_\_\_\_

Facility Name \_\_\_\_\_

Street Address\* \_\_\_\_\_

City\* \_\_\_\_\_ State\* \_\_\_\_\_ Zip Code\* \_\_\_\_\_

Phone #\* \_\_\_\_\_ Fax # \_\_\_\_\_

Form Submitted By \_\_\_\_\_

**CONTACT:**

Healthcare Professional \_\_\_\_\_ Phone # \_\_\_\_\_

**4. CLINICAL INFORMATION & MEDICAL ASSESSMENT**

Patient's Gestational Age: weeks \_\_\_\_\_ days \_\_\_\_\_ Birth Weight \_\_\_\_\_ g/kg/lbs

Current Weight \_\_\_\_\_ g/kg/lbs Date Recorded: \_\_\_\_\_

**Please document all diagnoses and provide the specific ICD-10 code for each.**

**1. Prematurity:**

Born at < 28 0/7wGA and less than 12 months old at start of RSV season

Born at < 28 0/7 - 32 0/7wGA and less than 6 months old at start of RSV season

Born at < 32 1/7 to 35 6/7wGA and less than 6 months old at start of RSV season AND

Prescriber has performed a RSV-Relative Risk Scale Assessment and found the patient to be at high-risk for RSV disease complicated by hospitalization

**2. Diagnosis of chronic lung disease (CLD) or bronchopulmonary dysplasia (BPD) of prematurity, and less than 24 months of age?**

Yes\*  No ICD-10: \_\_\_\_\_

Yes\*  No Developed an oxygen requirement or other pulmonary condition requiring treatment

Prescriber's Signature \_\_\_\_\_ Date \_\_\_\_\_

I authorize Elixir Specialty Pharmacy and its representatives to act as my agent to initiate and execute the insurance prior authorization process and, in doing so, to release clinical information via phone or fax to the appropriate PBM. **IMPORTANT NOTICE:** This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, and proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.

**CLINICAL INFORMATION & MEDICAL ASSESSMENT (CONT'D)**

Yes\*  No Patient is less than 24 months of age and required intervention or maintenance therapy for their condition within 6 months of the start of RSV season

Yes\*  No Patient is 12 - 24 months of age, meets all CLD or BPD requirements above and continues to require medical support for CLD within 6 months of the start of RSV season (check all that apply and provide last date received):

Oxygen (Date): \_\_\_\_\_  Corticosteroids (Date): \_\_\_\_\_

Diuretics (Date): \_\_\_\_\_  Bronchodilators (Date): \_\_\_\_\_

**3. Diagnosis of hemodynamically significant congenital heart disease and less than 24 months of age?  Yes\*  No**

Patient has the following condition(s):

Diagnosis of moderate-severe pulmonary hypertension ICD-10: \_\_\_\_\_

Cyanotic heart disease (in consultation with a pediatric cardiologist) ICD-10: \_\_\_\_\_

Acyanotic heart disease (receiving medication to control CHF & will require cardiac surgical procedures) ICD-10: \_\_\_\_\_

Medications to control CHF: \_\_\_\_\_

Last date received: \_\_\_\_\_

**4. Patient is younger than 24 months of age and has undergone cardiac transplantation during the RSV season.  Yes\*  No**

Date of Transplant: \_\_\_\_\_

**5. Neuromuscular Disease/Congenital Airway Abnormality:  Yes\*  No**

Severe neuromuscular disease that compromises handling of respiratory secretions during the first year of life ICD-10: \_\_\_\_\_

Congenital or other pulmonary abnormality ICD-10: \_\_\_\_\_

**6. Profoundly Immunocompromised or receiving chemotherapy during RSV season and less than 24 months of age  Yes\*  No**

ICD-10: \_\_\_\_\_ Drug Regimen: \_\_\_\_\_

**7. Patient has a diagnosis of:**

Cystic Fibrosis

Alpha-1 anti-trypsin deficiency with pulmonary involvement associated with another qualifier such as prematurity

Ciliary Dyskinesia

**8. Infants who are less than 12 months of age at the start of RSV season clinically diagnosed with Down's syndrome?  Yes  No**

**9. Other risk factors: \_\_\_\_\_**

**5. NICU HISTORY:**

Did the patient spend time in the NICU?  Yes  No

If yes, please attach the NICU Discharge Summary

Was there a NICU/HOSPITAL RSV dose administered?

Yes - Date(s): \_\_\_\_\_  No

Agency nurse to visit home for injection?  Yes  No

Agency Name: \_\_\_\_\_

**\*PLEASE PROVIDE CLINICAL DOCUMENTATION WHERE REQUESTED**

**RX**

Synagis® (palivizumab): Combination of 50- and/or 100-mg vials

Sig: Inject 15 mg/kg IM one time per month

Dispense Quantity: QS Refill x \_\_\_\_\_ months

Other / Epinephrine: \_\_\_\_\_

**EXPECTED DATE OF FIRST/NEXT INJECTION:** \_\_\_\_\_

Previous injection(s) given?  Yes  No

Please list all previous injection dates: \_\_\_\_\_