

RESPIRATORY SYNCYTIAL VIRUS (RSV)
TELEPHONE 1-800-834-8447 FAX 1-808-254-6153

1. PATIENT INFORMATION To be completed by the patient

| | | | | |
|------------------------------|--|--------------------------------|-----|---|
| Last Name | | First Name | | M.I. |
| Street Address | | | | |
| City | | State | ZIP | |
| Day Telephone # (+Area Code) | | Night Telephone # (+Area Code) | | Mobile Telephone # (+Area Code) |
| Date of Birth (MM/DD/YYYY) | | Social Security # | | Sex (Check One) <input type="checkbox"/> M <input type="checkbox"/> F |
| Parent/Guardian Name | | | | |

INSURANCE INFORMATION

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|---|--|---|--|--|
| Primary/Medical Insurance | | Secondary/Pharmacy Insurance | | |
| Cardholder Name & ID # (If Not Patient) | | Cardholder Name & ID # (If Not Patient) | | |
| Group/Policy # | | Group/Policy # | | |
| Insurance Telephone # (+Area Code) | | Insurance Telephone # (+Area Code) | | |
| Employer | | Medicaid # | | |

ALTERNATE SHIPPING ADDRESS

| | | | | |
|----------------|--|------------|-----|------|
| Last Name | | First Name | | M.I. |
| Street Address | | | | |
| City | | State | ZIP | |

Caremark is committed to protecting the privacy of your health information. We will hold your health information in confidence and will only use and disclose it in accordance with applicable law.

2. PHYSICIAN INFORMATION To be completed by the physician and staff

| | | | | |
|-----------------------------|--|-------------------------|----------------|--|
| Prescriber's Last Name | | Prescriber's First Name | | |
| Hospital/Clinic | | Office Contact | | |
| Street Address | | | | |
| City | | State | ZIP | |
| Telephone # (+Area Code) | | Fax # (+Area Code) | E-Mail Address | |
| Prescriber's License # | | DEA # | | |
| UPIN# | | Medicaid License # | | |
| Primary Care Physician Name | | Phone # | | |

STATEMENT OF MEDICAL NECESSITY

Patient's Gestational Age ___ Weeks ___ Days Birth Weight ___ g/kg/lbs
Current Weight ___ g/kg/lbs Date Recorded / /

MEDICAL CRITERIA (Check ALL that apply):

1. Prematurity (documentation required)
 Gestational Age of ≤ 28 Weeks, 0 Days and Less Than 12 Months at the Start of Synagis Season (Born on/after September 15, 2005)
 < 24 Weeks of Gestation (765.21) 24 Weeks of Gestation (765.22)
 25-26 Weeks of Gestation (765.23) 27-28 Weeks of Gestation (765.24)
 Gestational Age of 28 Weeks, 1 Day – 32 Weeks, 0 Days and Less Than 6 Months at the Start of Synagis Season (Born on/after March 15, 2006)
 29-30 Weeks of Gestation (765.25) 31-32 Weeks of Gestation (765.26)
 Gestational Age of 32 Weeks, 1 Day – 35 Weeks, 0 Days, born on/after March 15, 2006 requiring significant respiratory support in the neonatal period (positive pressure support)
 33-34 Weeks of Gestation (765.27) 35-36 Weeks of Gestation (765.28)
AND having an additional risk factor (Check all that apply)
 Child Care Attendance
 School-Aged Siblings ___ Specify Age(s) Severe Neuromuscular Disease
 Exposure to Environmental Air Pollutants (Includes Smoking Excludes Smoking)
 Congenital Abnormalities of Airway None Other _____

2. Diagnosis of Chronic Pulmonary Disease (CLD/BPD) AND less than 24 months of age? (Born on/after September 15, 2004 AND continuing medical treatment after March 15, 2006)
 Chronic Respiratory Disease Arising in the Perinatal Period (CLD) (770.7)
 Congenital Abnormality of Respiratory System (748.3 – 748.4)
 Other Respiratory Conditions of Fetus and Newborn (770.0 – 770.9)
 Other _____ ICD-9 _____
 Is Patient Receiving Medical Treatment Of (Check All That Apply and Provide Last Date Received)?
 Oxygen Date / / Corticosteroids Date / /
 Bronchodilator Date / / Diuretics Date / /

3. Diagnosis of Hemodynamically Significant Congenital Heart Disease AND Less Than 24 Months of Age? (Born on/after September 15, 2004 AND continuing medical treatment after March 15, 2006)
 Diagnosis of Moderate-Severe Pulmonary Hypertension (747.83)
 Cyanotic Heart Disease (770.83) Acyanotic Heart Disease
 Congestive Heart Failure (on medication) (428.9)
 Congenital Heart Disease (Please Specify) _____

4. Other Diagnosis _____ ICD-9 _____

OTHER MEDICAL HISTORY:

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|--|
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Additional Clinical Information Multiple Births
NICU HISTORY: No Yes (NICU Name _____)
Please Attach the NICU Discharge Summary
 Was There a NICU Dose Administered? No Yes Dates / /
 Did the Neonatologist Recommend Synagis Prior to Discharge? No Yes
 Expected Date of First/Next Injection / / Previous Injections? No Yes Dates / /
 Deliver Product to: Physician's Office Patient's Home
 Agency Nurse to Visit Home for Injection? No Yes

Rx
 Synagis® (palivizumab) 50 and/or 100 mg Vials NKDA
 Sig: Inject 15 mg/kg IM One Time Per Month
 Dispense Quantity: QS
 Refills: Through February 28, 2007 (1 dose per month, max: 5 doses)
 Other: _____ doses

| | |
|------------------------|------|
| Prescriber's Signature | Date |
| | |

3. FAX COMPLETED FORM TO THE HAWAII CAREMARK AT 1-808-254-6153

Please include copies of the patient's insurance cards (front & back) when faxing the referral to expedite benefit clearance.

Thank you for choosing Caremark!



Caremark Therapeutic Services
Hawaii Branch
970 North Kalaheo Avenue, Suite C-106
Kailua, HI 96734
808-254-6622

Thank you for choosing Caremark Therapeutic Services to provide Synagis for the upcoming 2006-07 RSV season. Synagis has been reformulated for this season making it simpler for physicians to administer the medication. It now comes in a ready-to-administer liquid form, a vast improvement from the prior form that needed reconstitution. Please follow the guidelines below for smooth service during this season. If you have any questions, please contact your local Caremark toll-free at 800-834-8447 (locally at 808-254-6622).

Guidelines for Completing the Caremark Synagis Referral Form

1. Fill out the form as completely as possible. **Do not forget to sign the form** – this will also serve as the prescription.
 - a. Per the consensus committee guidelines, prophylaxis should begin September 15, 2006 and last through February 2007.
 - b. The maximum number of doses should be limited to 5.
2. Fax the completed form to the Hawaii Caremark branch at 1-808-254-6153. Include appropriate documentation of medical necessity as well as appropriate insurance information. The front and back of the patient's insurance card is appropriate. Lack of documentation may result in delays in starting therapy.
3. Caremark will fax a receipt of confirmation to the originating fax number. If received during business hours (8:00am – 4:30pm, M-F) you will receive a receipt of confirmation the same day. If received after hours you will receive a receipt of confirmation the following business day. **If you do not receive this confirmation then the fax was not received by Caremark.** Please then re-fax the document.
4. A Caremark Pharmacy Service Representative (PSR) will work with the Caremark Benefits team and the insurance company to obtain any authorizations needed to dispense the medication.

Insurance Approvals:

1. PSR notifies the physician's office of the insurance approval and schedules the first shipment of the medication.
2. PSR notifies the patient's parent(s)/guardian(s) of the approval and quotes the insurance co-pay (if applicable). The patient's parent(s)/guardian(s) is also notified of the medication shipment date and reminded to schedule an appointment with their physician.
3. If treatment is declined, the physician's office will be notified immediately and the shipment will be canceled until Caremark is notified by the physician's office.

Insurance Denials:

1. Patient's parent(s)/guardian(s) notified of denial and quoted payment. If treatment is to be received, the parent(s)/guardian(s) will be notified to schedule an appointment with their physician
2. PSR will notify the physician's office of the decision to receive/decline treatment. If treatment is accepted, the first shipment of the medication is scheduled. If treatment is declined, no shipment will be scheduled. If the physician feels the treatment should still be administered, a Caremark PSR would be on hand to work with the physician and the insurance company to collect all appropriate information to obtain an approval. Approvals are not guaranteed but, with appropriate documentation, may be obtained for patients that qualify under the current guidelines.

Refill Procedures

- * Refill doses to be dispensed will be based on a growth rate of 0.675 kg/month for infants 1-6 months of age and 0.3 kg/month for those 7-24 months of age.
1. PSR will contact the physician's office to schedule the refill shipment. This will be approximately 30 days after the prior shipment.
 2. Patient's parent(s)/guardian(s) are notified of the shipment and reminded to schedule an appointment with their physician.
 3. If treatment is declined, the physician's office will be notified immediately and the shipment will be canceled until Caremark is notified by the physician's office.

Miscellaneous information:

1. All medications are shipped via FedEx for delivery the following day. We ship medication out Mondays – Thursdays. Shipments for Mondays will be sent on the previous Thursday via FedEx or delivered the previous Friday by the pharmacist or courier. This is at no additional charge to the patient or physician's office.
2. Caremark will collect data on all patients in which orders have been received. This data includes, but does not exclude, weight, shipment/administration date(s), # of doses ordered/administered, authorization/denial dates & doses, location of the patient, and the administering physician.