Access 360™ Fax Cover Sheet

For support with your referral, please contact Access 360: Phone: 1-877-778-9010, Fax: 1-866-252-1749.

In reference to:

Required ★

Patient Name: _____

Prescriber Name: _____ Prescriber Fax: _____

If you know which Specialty Pharmacy Provider (SPP) to send your referral to:

1. Fax your referral directly to the SPP of your choice

If you need support from Access 360:

1. Submit this completed fax cover sheet AND
2. A Statement of Medical Necessity (SMN/Referral) signed and dated by the prescriber AND
3. A signed/dated Patient Authorization Form AND
4. Fax to (866) 252-1749

Required ★ **Support Needed From Access 360 (check all that apply): Patient Authorization Form and signed/dated SMN/Referral are required.**

Comments: _____

☐ **Submit SMN/referral to the following SPP:** _____ **Telephone:** _____ **Fax:** _____
☐ **SPP Research:** I don't know which SPP; please research
☐ **SMN/Referral Follow Up:** Follow up with SPP to confirm shipment
☐ **Benefit Investigation:** Identify patient-specific coverage for Synagis (includes Medical and Pharmacy benefit plans)
☐ **Prior Authorization (PA) Research:** I don't know insurance approval requirements; please research
☐ **Prior Authorization Submission Assistance and Follow Up:** Assist in PA submission and/or follow up
☐ **Appeal Support:** Help me understand appeal options and payer-specific documentation/process
☐ **Copay Assistance:** My patient is insured but needs financial assistance
☐ **MedImmune Assistance Program (MAP):** My patient is uninsured or rendered uninsured and would like to apply to receive Synagis at no cost

The following is required to apply for MAP:

1. *A complete MAP application, signed and dated by patient/caregiver and prescriber.*
2. *A complete, signed, and dated Patient Authorization Form.*
3. *A complete, signed, and dated Statement of Medical Necessity.*
4. *Documentation of patient's income, submitted within 21 days of application submission (see MAP application for details).*
5. *Documentation of an appeal to the applicant's insurance company for Synagis® (palivizumab) coverage AND insurance company's subsequent denial of that appeal (applies to rendered uninsured applicants only).*

☐ **I give MedImmune permission to contact this patient to help obtain a signed Patient Authorization Form**

I hereby authorize the Access 360 program to convey the attached prescription on my behalf to the pharmacy chosen by or for the Patient, and receive information on the status and related matters. By signing below, I certify that a) Synagis is medically necessary; b) I have received the necessary authorization to release the information included on this form and the attached SMN and other protected health information (as defined by HIPAA) to MedImmune Access 360 and contracted dispensing pharmacy or other contractors for the purpose of seeking reimbursement, assisting in initiating or continuing therapy and/or the evaluation of the patient's eligibility for MedImmune Assistance Program related to MedImmune products, as a break in treatment would negatively impact the patients therapeutic outcome; and c) I allow MedImmune Access 360 to convey, on my behalf to the pharmacy chosen by the above-named patient, the prescription described herein.

Required ★ **Prescriber or Prescriber's Designee (required if Access 360 support requested)**

Print Name: _____ **Signature:** _____ **Date:** _____

Common Synagis ICD-9 Codes

Indicate appropriate ICD-9 of primary and/or secondary diagnosis

Common ICD-9 codes for Synagis:

Diagnosis/Description	Code	Diagnosis/Description	Code
<24 completed weeks of gestation	765.21	Chronic lung disease of prematurity (CLDP)*	770.7
24 completed weeks of gestation	765.22	Bronchopulmonary dysplasia (BPD)*	770.7
25–26 completed weeks of gestation	765.23	Congenital heart disease (CHD)†	746.9
27–28 completed weeks of gestation	765.24	Extreme immaturity	765.0
29–30 completed weeks of gestation	765.25	Other preterm infants	765.1
31–32 completed weeks of gestation	765.26		
33–34 completed weeks of gestation	765.27	* Chronic respiratory disease arising in the perinatal period.	
35–36 completed weeks of gestation	765.28	† Unspecified anomaly of heart. Congenital anomaly of heart not otherwise specified (NOS).	

This form should not be construed as coding advice. Each practitioner is solely responsible for ensuring the accuracy of the information submitted.

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Statement of Medical Necessity (SMN)

SYNAGIS® PALIVIZUMAB | MedImmune Specialty Care Division of AstraZeneca

Specialty Pharmacy Provider Name _____ Phone _____ Fax _____

Patient Information

Name (First, Last) _____ DOB _____ SSN _____

Address _____ City _____ State _____ Zip _____

Primary Guardian _____ Secondary Guardian _____

Primary Phone # _____ Secondary Phone # _____

Patient one of multiple births? ☐ Yes ☐ No / If yes, is sibling(s) referral being submitted simultaneously? ☐ Yes ☐ No

Sibling name(s) _____

Insurance Information

☐ No Insurance ☐ Copy of Medical and/or Pharmacy Card Included

	Primary Insurance	Secondary Insurance	Pharmacy Benefit
Insurance Name			
Cardholder Name (if not patient)/DOB			
Group Number			
Policy Number			
Insurance Phone #			
BIN #	N/A	N/A	

Independent Practice Association (IPA) / Accountable Care Organization (ACO) (if applicable):

Prescriber Information	Treating	Referring
Provider Name		
Site Name		
Site Address (Street/City/State/Zip)		
Telephone # / Fax #	/	
Office Contact		
NPI #		N/A
License # / Tax ID #	/	N/A
Medicaid Provider # / DEA #	/	N/A

Diagnosis

Patient's gestational age (GA) at birth_____ **Current weight**_____**kg** _____**lbs-oz** **Date current weight recorded** _____

PRIMARY: ICD-9 _____ **or ICD-10** _____

SECONDARY: ICD-9 _____ **or ICD-10** _____

See fax cover sheet for common ICD-9 codes used for Synagis

CLINICAL INFORMATION: ☐ Medical records included

1. ☐ **CLDP/BPD: Diagnosis of chronic lung disease of prematurity/bronchopulmonary dysplasia and ≤24 months of age** (Specific Diagnosis Code _____)
   Is patient receiving medical treatment (check all that apply and provide last date received)?:
   ☐ Oxygen date: _____ ☐ Corticosteroids date: _____ ☐ Bronchodilators date: _____ ☐ Diuretics date: _____
2. ☐ **CHD: Diagnosis of hemodynamically significant congenital heart disease and ≤24 months of age** (Specific Diagnosis Code _____)
   Patient has the following condition (check all that apply):
   ☐ Medications for CHD: _____ ☐ Moderate to severe pulmonary hypertension
   Date CHD medications were last received: _____ ☐ Cyanotic CHD
3. **Indicate applicable risk factors:**
   ☐ Congenital abnormality of airways ☐ Severe neuromuscular disease ☐ Pre-school or school-aged sibling(s) (<5 years of age)
   ☐ Family history of asthma or wheezing ☐ Residency in rural setting ☐ Daycare attendance: 2 unrelated children for >4 hours/week
   ☐ Multiple births ☐ Exposure to environmental tobacco smoke or air pollutants
4. **Additional information:**
   ☐ Other medical history: _____

Prescription Information

Was Synagis® previously administered (NICU/hospital/other location)? ☐ No ☐ Yes Date(s): _____

Expected date of first/next dose: _____

Deliver product to: ☐ Office ☐ Patient's home ☐ Clinic Clinic Name and Location: _____

Agency nurse to visit home for injection? ☐ No ☐ Yes Agency name and Tax ID number: _____

Required ✶

Rx ☐ Synagis® 50 mg and/or 100 mg vials. Inject 15 mg/kg IM one time per month. QS to achieve 15 mg/kg dose. **Refills:** _____
☐ Epinephrine 1:1000 amp. Sig: Inject 0.01 mg/kg IM/SC as directed
☐ Known allergies: _____ ☐ Ancillary supplies and kits as needed for administration: _____

Required ✶ **Original signature of prescriber** _____ **Date** _____

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