HIGHMARK WESTERN NEW YORK

Medicaid Managed Care
Child Health Plus

# *Respiratory Syncytial Virus Enrollment Form*

Highmark Blue Cross Blue Shield of Western New York (Highmark BCBSWNY) partners with Amerigroup companies to administer certain services to Medicaid Managed Care (MMC) and Child Health Plus (CHPlus) members. Please note, this information is specific to the MMC and CHPlus programs only.

**Phone: 1-866-231-0847**
**Fax referral to: 1-844-493-9206**

Date: _____

Date needed by: _____

Ship to: ☐ Patient ☐ Office ☐ Other:_____

**Section I — member and provider information**

| | |
|---|---|
| Member name (last, first, middle initial) | |
| Member identification number | Member date of birth |
| Prescriber name | Prescriber NPI |
| Prescriber address (street, city, state ZIP + 4) | |
| Prescriber telephone number | |
| Billing provider name | Billing provider NPI |

**Section II — clinical information for all prior authorization requests**

Was Synagis® administered when the child was hospitalized? ☐ Yes ☐ No

If yes, indicate the date(s) of administration in the space(s) provided. (No more than five doses will be authorized, inclusive of any hospital-administered doses.)

1. 2. 3.

| | |
|---|---|
| Current weight — child (in kg) | Date child weighed |
| Calculated dosage of Synagis (15 mg per kg of body weight) | |
| Case-specific diagnosis/ICD-10 | |

**https://providerpublic.mybcbswny.com**

Amerigroup Partnership Plan, LLC provides management services for Highmark Blue Cross Blue Shield of Western New York's managed Medicaid.
Amerigroup Partnership Plan, LLC brinda servicios administrativos para Medicaid administrado de Highmark Blue Cross Blue Shield of Western New York.
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NYWPEC-2466-21 January 2022

Providers are required to complete one of Section IIIA, IIIB, IIIC, IIID, IIIE or IIIF — depending on the child's medical condition — for a prior authorization request to be considered for approval.

**Section IIIA — clinical information for chronic lung disease**

The child has chronic lung disease of prematurity. ☐ Yes ☐ No

Did the child require oxygen at greater than 21% for at least the first 28 days after birth? ☐ Yes ☐ No

Indicate the child's gestational age at delivery (in weeks and days).
Weeks: Days:

Check all therapies below that the child has continuously used over the past six months.
☐ Corticosteroid ☐ Diuretic ☐ Supplemental oxygen

**Section IIIB — clinical information for congenital heart disease**

The child is younger than 12 months of age at the start of the RSV season and has hemodynamically significant congenital heart disease. ☐ Yes ☐ No

**Section IIIC — clinical information for cardiac transplant**

The child is younger than 24 months of age at the start of the RSV season and is scheduled to undergo a cardiac transplantation during the RSV season. ☐ Yes ☐ No

**Section IIID — clinical information for preterm infants**

The child is younger than 12 months of age at the start of the RSV season and was born before 29 weeks of gestation (in other words, zero days through 28 weeks, six days). ☐ Yes ☐ No

Indicate the child's gestational age at delivery (in weeks and days).
Weeks: Days:

**Section IIIE — clinical information for pulmonary abnormalities and neuromuscular disease**

The child is younger than 12 months of age at the start of the RSV season and has a neuromuscular disease or congenital abnormality that impairs the ability to clear secretions from the upper airway because of an ineffective cough. ☐ Yes ☐ No

If yes, indicate the disease or anomaly.

**Section IIIF — clinical information for immunocompromised children**

The child is younger than 24 months of age at the start of the RSV season and is profoundly immunocompromised due to:

- Solid organ transplant ☐ Yes ☐ No
- Stem cell transplant ☐ Yes ☐ No
- Receiving chemotherapy ☐ Yes ☐ No
- AIDS ☐ Yes ☐ No
- Other ☐ Yes ☐ No

If other, indicate the cause of the child's immunodeficiency.

**Section IV — authorized signature**

| Prescriber signature | Date signed |
|---|---|
| | |

**Section V — additional information**

Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may be included here.