

**Respiratory Syncytial Virus Prophylaxis  
PRIOR REVIEW/CERTIFICATION FAXBACK FORM**

**INCOMPLETE FORMS MAY DELAY PROCESSING**

**ALL NC PROVIDERS MUST PROVIDE THEIR 5- DIGIT BCBSNC PROVIDER ID# BELOW**

PRESCRIBER INFORMATION		PATIENT INFORMATION	
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME	
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID	
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH	
PRACTICE ADDRESS	CITY	STATE	ZIP

**Specialty Pharmacy Utilized:** \_\_\_\_\_

**Requested administration start date:** \_\_\_\_\_ **Dx Code:** \_\_\_\_\_

1. **Is the patient 24 months of age or younger?**..... Yes No
2. **Does the patient have any one of the following:**
  - a. Chronic lung disease (CLD) or bronchopulmonary dysplasia(BPD) ..... Yes No
  - b. Hemodynamically significant congenital heart disease (CHD)..... Yes No
  - c. Congenital abnormalities of the airway or neuromuscular disease and  
Gestational age < 35 weeks and < 1 year of age ..... Yes No
  - d. Gestational age at birth 29 weeks 0 days to 31 weeks 6 days and  
< 6 months age at start of RSV season..... Yes No
  - e. Gestational age at birth less than 29 weeks and < 1 year of age at start if RSV season ... Yes No
3. **Is the request for up to but not more than 5 doses?**..... Yes No
4. **Was the patient's Gestational Age at birth 32 weeks 0 days - 34 weeks 6 days and  
< 3 months of age at the start of RSV season?** ..... Yes No
5. **Does the patient attend daycare and/or have sibling(s) below the age of 5 in the home?** .... Yes No
6. **Is the request for up to but not more than 3 doses?**..... Yes No

The medical policy used for respiratory syncytial virus prophylaxis is based on the current American Academy of Pediatrics (AAP) recommendations.

**Please certify the following by signing and dating below:**

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber signature: \_\_\_\_\_ Date: \_\_\_\_\_

**For BCBSNC members, fax form to 1-800-795-9403  
For NC State Health Plan members (Member ID starts with YPY), fax form to 1-866-225-5258**