Anthem

Serving Hoosier Healthwise, Healthy Indiana Plan
and Hoosier Care Connect

Respiratory Syncytial Virus Enrollment Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-864-7860.
Provider Help Desk: 1-866-408-6132 (Hoosier Healthwise)
1-844-533-1995 (Healthy Indiana Plan)
1-844-284-1798 (Hoosier Care Connect)

Today's Date

Month	Day	Year

Note: This form must be completed by the prescribing provider.

****All sections must be completed or the request will be returned****

Patient's Medicaid #_____	Date of Birth:_____
Patient Name:_____	Prescriber's Name: _____
Prescriber's IN License #:_____	Specialty _____
Prescriber's NPI #:_____	Prescriber's Signature: _____
Return Fax #: _____	Return Phone #: _____
Check box if requesting retro-active PA: ☐	Date(s) of service requested for retro-active eligibility (if applicable): _____

Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).

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https://providers.anthem.com/in

Providers who are contracted with Anthem Blue Cross and Blue Shield to serve Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect through an accountable care organization (ACO), participating medical group (PMG) or Independent Physician Association (IPA) are to follow guidelines and practices of the group. This includes but is not limited to authorization, covered benefits and services, and claims submittal. If you have questions, please contact your group administrator or your Anthem network representative.
INBCBS-CD-027498-23 June 2023

1. Patient information

Actual gestational age: _____ weeks _____ days

Current age (must be < 24 months): _____ months

Current weight: _____ ☐ kg ☐ lb

2. Prescription information

☐ Inject 15 mg/kg IM once per month through March 31

☐ Other:_____

3. Palivizumab Prior Approval Criteria Guidelines for a maximum of five (5) doses (approval will be granted under any of the following circumstances):

☐ Infants < 12 months of age born preterm before 32 weeks gestation

☐ Infants < 12 months of age born with chronic lung disease (CLD) or bronchopulmonary dysplasia (BPD) (defined as an oxygen requirement for at least 28 days after birth or those that developed an oxygen requirement)

Please provide dates of oxygen supplementation:

_____

☐ Infants < 12 months of age and requiring medical therapy for hemodynamically significant heart disease or cardiomyopathies

Please provide relevant diagnoses/medication intervention:

_____

☐ Infants < 12 months of age with neuromuscular disease or congenital abnormalities of the airways

Please provide relevant diagnoses:

_____

☐ Infants and children < 24 months of age who required at least 28 days of supplemental oxygen after birth, and continue to require medical intervention (supplemental oxygen, chronic corticosteroid use, diuretic therapy)

Please provide dates of oxygen supplementation/medication intervention:

_____

☐ Infants and children < 24 months of age who will be profoundly immunocompromised during the RSV season (solid organ or hematopoietic stem cell transplant, chemotherapy, or other condition that leaves the infant or child profoundly immunocompromised, including those awaiting heart transplant)

Please Explain:

_____

☐ Infants and children < 24 months of age with evidence of hemodynamically significant coronary heart disease, cardiomyopathies, or pulmonary hypertension

Please Explain:

_____

Note: *Prophylaxis will be given only until the infant or child reaches a maximum of five (5) doses or the end of the RSV season, whichever comes first.*

The Respiratory Syncytial Virus (RSV) season is defined as November 1st through March 31st. The Office of Medicaid Policy & Planning may extend the season based on statewide virology data. Administration of additional doses will require separate prior authorization. [Please note that the criterion presented on the form pertains to the <Indiana Health Coverage Programs>/<Plan Name> pharmacy benefit only].