AstraZeneca Access 360™ Support Request Form

SYNAGIS® PALIVIZUMAB | AstraZeneca Access 360™

Services Requested: Access 360 will perform standard support services, including Benefit Investigation, Pharmacy Coordination, and identify affordability options. Additional services and support can be provided with completion of the **Patient Authorization Form (PAF)** on file and at the request of the Provider's office. Please select which additional services are required:

☐ Prior Authorization Support ☐ Appeal Support* ☐ Claim/Billing Support ☐ Other: _____

Once completed and signed, fax this form to **1-844-329-2360.**

**To request appeal support, include a copy of the insurance denial letter.*

1 Patient Information

First Name: _____ Last Name: _____ Patient DOB: ____/____/____ Gender: ☐ M ☐ F

Street: _____ City: _____ State: _____ ZIP: _____

Parent/Legal Guardian Name: _____ Relationship to Patient: _____

Parent/Legal Guardian Preferred Phone #: ☐ Home ☐ Mobile _____ Parent/Legal Guardian Email: _____

Parent/Legal Guardian preferred language (if other than English): _____

Okay to contact Parent/Legal Guardian? ☐ Yes ☐ No Okay to leave a detailed voicemail? ☐ Yes ☐ No

2 Insurance Information

NOTE: Please provide copies of the front and back of all insurance cards. ☐ No insurance ☐ Check Buy and Bill benefits ☐ Check Home Health

	Primary Medical Insurance	Secondary Medical Insurance	Pharmacy Insurance
Insurance Provider			
Insurance Phone #			
Cardholder Name (if not the patient)			
Cardholder DOB			
Policy #			
Group #			
BIN/PCN	X	X	

3 Provider Information

Prescriber Name: _____ Specialty: _____

Practice Name: _____

Street: _____ City: _____ State: _____ ZIP: _____

Phone #: _____ Fax #: _____ Email: _____

Prescriber NPI #: _____ Tax ID #: _____

Medicaid Provider Number: _____ Other Provider ID (if applicable): _____

Office Contact Name: _____ Office Contact Phone #: _____ Office Contact Email: _____

I authorize Access 360 program to convey the attached prescription on my behalf to the pharmacy chosen below and to receive information on the status and related matters. By signing below, I certify that the medicine prescribed on this form is medically necessary based on my independent medical judgment, and I have received the necessary authorization to release the information included on this form and other Protected Health Information (as defined by HIPAA) to Access 360, the dispensing pharmacy, or other contractors for the purpose of seeking reimbursement or assisting in initiating or continuing therapy. Each practitioner is solely responsible for ensuring the accuracy of the information submitted.

By signing this form, I certify that (1) I have received the necessary authorization to release the information included on this form and other related Protected Health Information (as defined by HIPAA) to Access 360, including employees, contractors, or affiliates of AstraZeneca, and health care plans for programs, dispensing pharmacy(ies) or other entities, for the purposes of treatment and payment support, and (2) I have obtained any necessary authorization to allow Access 360 to contact the patient, if not included with this submission, to obtain a signed Access 360 Patient Authorization Form.

Prescriber Name: _____

SIGN HERE **Prescriber Signature** _____ **Date:** ____/____/____

Patient First Name: _____

Patient Last Name: _____ Patient DOB: ____/____/____

4 Clinical Information

Patient's gestational age at birth: _____ Current weight: _____ lbs _____ oz or _____ grams Date current weight recorded: _____

Diagnosis Code(s): _____

CLINICAL INFORMATION: Birth weight: _____ ☐ Medical records included

1. ☐ **BPD/CLDP: Diagnosis of bronchopulmonary dysplasia/chronic lung disease of prematurity 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 any of the following (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
   ☐ Family history of asthma or wheezing
   ☐ Multiple births
   ☐ Severe neuromuscular disease
   ☐ Residency in rural setting
   ☐ Exposure to environmental tobacco smoke or air pollutants
   ☐ Pre-school or school-aged sibling(s) (<5 years of age)
   ☐ Daycare – care at any home or facility with any number of infants or young toddlers

IMPORTANT SAFETY INFORMATION

- SYNAGIS is contraindicated in children who have had a previous significant hypersensitivity reaction to SYNAGIS
- Adverse reactions occurring greater than or equal to 10% and at least 1% more frequently than placebo are fever and rash. In post-marketing reports, cases of severe thrombocytopenia (platelet count <50,000/microliter) and injection site reactions have been reported

Please see additional Important Safety Information on next page, and accompanying full Prescribing Information.

5 Prescription Information

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

Expected date of next dose: _____

Deliver medicine to: ☐ Office ☐ Patient's home ☐ Please Check Clinic Name and Location: _____

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

Rx SYNAGIS 50 mg and/or 100 mg vials. Inject 15 mg/kg IM one time per month. Quantity sufficient to achieve 15 mg/kg dose.

Refills: (Please enter "0" if no refills remain) _____ **(REQUIRED)**

☐ Epinephrine 1:1000 amp. Sig: Inject 0.01 mg/kg IM/SC as directed ☐ Known allergies: _____

☐ Ancillary supplies and kits as needed for administration: _____

Specialty Pharmacy Provider (SPP)

SPP: _____ ☐ No Preference† ☐ Payer Contracted Pharmacy

†*If you have questions about in-network SPP(s) for your patient, contact Access 360 at 1-844-275-2360.*

Prescriber Name: _____

SIGN HERE **Prescriber Signature** _____ **Date:** ____/____/____

IMPORTANT SAFETY INFORMATION

- SYNAGIS is contraindicated in children who have had a previous significant hypersensitivity reaction to SYNAGIS
- Cases of anaphylaxis and anaphylactic shock, including fatal cases, have been reported following initial exposure or re-exposure to SYNAGIS. Other acute hypersensitivity reactions, which may be severe, have also been reported on initial exposure or re-exposure to SYNAGIS. The relationship between these reactions and the development of antibodies to SYNAGIS is unknown. If a significant hypersensitivity reaction occurs with SYNAGIS, its use should be permanently discontinued. If a mild hypersensitivity reaction occurs, clinical judgment should be used regarding cautious readministration of SYNAGIS
- As with any intramuscular injection, SYNAGIS should be given with caution to children with thrombocytopenia or any coagulation disorder
- Palivizumab may interfere with immunological-based RSV diagnostic tests, such as some antigen detection-based assays
- Adverse reactions occurring greater than or equal to 10% and at least 1% more frequently than placebo are fever and rash. In post-marketing reports, cases of severe thrombocytopenia (platelet count <50,000/microliter) and injection site reactions have been reported

INDICATION

SYNAGIS is indicated for the prevention of serious lower respiratory tract disease caused by respiratory syncytial virus (RSV) in pediatric patients:

- with a history of premature birth (≤35 weeks gestational age) and who are 6 months of age or younger at the beginning of RSV season
- with bronchopulmonary dysplasia (BPD) that required medical treatment within the previous 6 months and who are 24 months of age or younger at the beginning of RSV season
- with hemodynamically significant congenital heart disease (CHD) and who are 24 months of age or younger at the beginning of RSV season

LIMITATIONS OF USE

The safety and efficacy of SYNAGIS have not been established for treatment of RSV disease.

DOSING

The recommended dose of SYNAGIS is 15 mg/kg of body weight given monthly by intramuscular injection. The first dose of SYNAGIS should be administered prior to commencement of the RSV season and the remaining doses should be administered monthly throughout the RSV season. Children who develop an RSV infection should continue to receive monthly doses throughout the RSV season.

The efficacy of SYNAGIS at doses less than 15 mg/kg, or of dosing less frequently than monthly throughout the RSV season, has not been established.

Please see accompanying full Prescribing Information for SYNAGIS, including Patient Information.

You are encouraged to report negative side effects of AstraZeneca prescription drugs by calling 1-800-236-9933. If you prefer to report these to the FDA, either visit www.FDA.gov/medwatch or call 1-800-FDA-1088.

Once completed and signed, fax this form to 1-844-329-2360. You may need to provide additional information depending on the type of support requested.

1-844-ASK-A360 (1-844-275-2360) **1-844-FAX-A360** (1-844-329-2360) **www.MyAccess360.com**

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