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Synagis (Palivizumab) Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
Synagis (Palivizumab)	_____	_____	Specify: _____

7. Diagnosis: _____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Gestational Age at Birth (week,day) : _____

Iowa Medicaid follows the current American Academy of Pediatrics Guidelines for eligibility criteria for prophylaxis of high-risk infants and young children. Prior authorizations will be approved for administration during the RSV season for a maximum of 5 doses per patient. No allowances will be made for a sixth dose. Patients, who experience a breakthrough RSV hospitalization, should have their monthly prophylaxis discontinued, as there is an extremely low likelihood of a second RSV hospitalization in the same season.

Patient meets at least one of the following criterion:

Chronic Lung Disease (CLD) of Prematurity:

- ☐ Patient is less than 12 months of age at start of therapy and has CLD of prematurity (defined as gestational age less than 32 weeks and required greater than 21% oxygen for at least the first 28 days after birth. (Please attach chart notes documenting oxygen use)
- ☐ Patient is 12 months to < 24 months meeting the CLD of prematurity definition above, and continues to require medical support during the 6-month period before the start of the second RSV season (defined as one or more of the following):
  - ☐ Chronic corticosteroid therapy Drug Name, Dose & Therapy Dates: _____
  - ☐ Diuretic therapy Drug Name, Dose & Therapy Dates: _____

☐ Supplemental oxygen Therapy Dates: _____

Premature Infants (without CLD of Prematurity or CHD):

☐ Patient is less than 12 months of age at start of therapy with a gestational age less than 29 weeks.

Neuromuscular Disorders or Anatomic Pulmonary Abnormalities: Patient is 12 months of age or younger at the start of therapy and has either severe neuromuscular disease or congenital anomaly that impairs the ability to clears ecretions from the upper airway due to an ineffective cough.

- Describe: _____

Hemodynamically Significant Congenital Heart Disease (CHD): Patient is less than 12 months of age at start of therapy and has hemodynamically significant congenital heart disease further defined by any of the following:

☐ Patient with acyanotic heart disease who is receiving medication to control congestive heart failure and will require cardiac surgical procedures.

- Hemodynamically Significant CHD diagnosis: _____
- Current Medication(s): Drug Name, Dose & Therapy Dates: _____
  _____
- Cardiac Surgical Procedure: Procedure & Expected Completion Date: _____

☐ Patient with moderate to severe pulmonary hypertension

☐ Requests for patients with cyanotic heart defects will be considered with documentation of consultation with a pediatric cardiologist that recommends patient receive palivizumab prophylaxis. (Provide consultation notes)

Immunodeficiency: Patient is less than 24 months of age at start of therapy and is profoundly immunocompromised during the RSV season (e.g., severe combined immunodeficiency, advanced acquired immunodeficiency syndrome, receiving chemotherapy).

- Describe: _____

Please indicate if the patient has received any previous Synagis® doses this RSV season. If yes, please provide the date(s) of administration: ☐ No ☐ Yes Administration Date(s): _____

Please indicate setting in which Synagis is to be administered: _____

Attach lab results and other documentation as necessary.

9. Physician signature

_____ _____

Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.