NC Medicaid
Synagis® (palivizumab) Prior Authorization Form

Fax this form to 866-422-8981

Please fill out all applicable sections on all pages completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the prior authorization). Information contained in this form is Protected Health Information under HIPAA.

REQUESTER INFORMATION

Requester Last Name: ______________________________

Requester First Name: ______________________________

Requester Phone: ______________ Requester Fax: ______________ Date: ______________

BENEFICIARY INFORMATION

Beneficiary Last Name: ______________________________

Beneficiary First Name: ______________________________

Beneficiary ID: ______________ Date of Birth: ______________ Beneficiary Phone: ______________

Sex: ☐ Male ☐ Female

Allergies: ______________________________

PRESCRIBER INFORMATION

Prescriber Last Name: ______________________________

Prescriber First Name: ______________________________

Specialty: ______________________ Prescriber NPI: ______________________

Prescriber Phone: ______________________ Prescriber Fax: ______________________

DRUG INFORMATION

Drug Name: ______________________ Drug Strength: ______________________

Drug Form: ______________________ Dosing Frequency: ______________________

Quantity: ______________________ Length of Therapy: ______________________

Dose Instructions: ______________________________

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Beneficiary's Full Name: ____

CLINICAL INFORMATION

The provider should use the "Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age" form to request Synagis® outside of policy criteria, for coverage outside the defined coverage period, if Beyfortus® was administered during the current season, or if maternal vaccine Abrysvo® was administered during pregnancy.

This is the beneficiary's ☐ first RSV season ☐ second RSV season

Criteria for infants younger than 12 months AND in their first RSV season:

1. Was the beneficiary born premature before 29 weeks and 0 days of gestation?

   ☐ Yes ☐ No

   Birth EGA: ________________ Weeks: ______________ Days: ____________________

Criteria for infants < 24 months of age AND in their first RSV season with one of the following diagnoses:

2. Does the beneficiary have one of the following diagnoses?

   ☐ Hemodynamically significant acyanotic heart disease (CHD), receiving medication to control congestive heart failure, and will require cardiac surgical procedures

   ☐ Moderate to severe pulmonary hypertension

   ☐ Neuromuscular disease or pulmonary abnormality that impairs the ability to clear secretions from the upper airways because of ineffective cough

   ☐ Cyanotic heart disease with cardiologist recommendation (submit documentation of cardiologist recommendation)

   ☐ Cystic fibrosis with clinical evidence of CLD and/or nutritional compromise

   ☐ Profoundly immunocompromised during RSV season

   ☐ Undergoing cardiac transplantation during RSV season

   ☐ Chronic Lung Disease (CLD) of prematurity (defined as birth at < 32 weeks and 0 days gestation, and requiring > 21% oxygen for at least the first 28 days after birth)

Note: Please submit documentation of CLD as defined to meet criteria approval (e.g. NICU discharge summary).

Criteria for infants < 24 months of age AND in their second RSV season with one of the following diagnoses:

3. Does the beneficiary have one of the following diagnoses?

   ☐ Profoundly immunocompromised during RSV season

   ☐ Cardiac transplantation during RSV season

   ☐ Cystic Fibrosis with manifestations of severe lung disease (previous hospitalization for pulmonary exacerbation in first year or abnormalities on chest radiography or chest computed tomography that persist when stable) or weight-for-length < 10th percentile

Beneficiary's Full Name: ______________________________

- ☐ CLD of prematurity (see above definition) and continue to require medical support supplemental oxygen, chronic corticosteroid or diuretic therapy during the six-month period before start of second RSV season. **Indicate treatment(s) for CLD**:
  - ☐ chronic corticosteroid therapy
  - ☐ diuretic therapy
  - ☐ supplemental oxygen
  - ☐ no medical support required

Note: Please submit documentation of CLD as defined to meet criteria approval (e.g. NICU discharge summary).

☐ Attachments

By signing this request, the prescriber attests that the information provided herein is true and accurate to the best of his/her knowledge.

Prescriber Signature: ______________________________ **Date**: ____________________

Mail requests to:

Prime Therapeutics Management Prior Authorization Program
Attn: GV – 4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 844-620-6116

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