Government of District of Columbia Department of Health Care Finance

SYNAGIS (Palivizumab)

Prior Authorization Request

REQUEST DATE: / /

PATIENT INFORMATION

PATIENT'S MEDICAID ID NUMBER

PATIENT'S DATE OF BIRTH / /

PATIENT'S FULL NAME

PRESCRIBER INFORMATION

PRESCRIBER'S FULL NAME

PRESCRIBER PHONE NUMBER: – –

PRESCRIBER FAX NUMBER: – –

PRESCRIBER SPECIALTY:

PRESCRIBER NPI #: –

INFORMATION REQUIRED FOR PRIOR AUTHORIZATION APPROVAL

1. **A COPY OF PATIENT'S NICU DISCHARGE SUMMARY MUST ACCOMPANY THIS PRIOR AUTHORIZATION REQUEST**
2. Authorization Period: Five (5) months between October - May
3. Patient Information:
   a. Weight at Birth _____ lbs/kgs b. Gestational Age _____ weeks _____ days
   c. Most Current Weight _____ lbs/kgs d. Date Measured / /
4. Current request for SYNAGIS (palivizumab) _____ mg IM every 28 days with _____ refills
5. List of all previously administered SYNAGIS (palivizumab) injections during this season (if any) with dates given (max 5 doses)

   _____

   _____
6. Criteria for SYNAGIS use: Patient must meet one of the following Criteria which adhere to the 2014 American Academy of Pediatrics (AAP) guideline
   - ☐ a. Infant < 12 months of age born <29 weeks gestation without chronic lung disease (CLD) or chronic heart disease (CHD)
   - ☐ b. Infant <12 months of age born <32 weeks gestation with CLD of prematurity who received >21 percent oxygen for atleast 28 days after birth
   - ☐ c. Infant<12 months of age born with hemodynamically significant CHD characterized by (check all that apply):
     - ☐ Acyanotic Heart Disease
     - ☐ Requires a cardiac surgical procedure
     - ☐ Currently receiving medication to control heart failure (list the medications) _____
     - ☐ Moderate to Severe Pulmonary Hypertension
     - ☐ Other (please specify) _____
   - ☐ d. Infant <12 months of age born with neuromuscular disease or a congenital heart anomaly that impairs the ability to clear secretions from the upper airway.
   - ☐ e. Infant <12 months with Cystic Fibrosis and clinical evidence of CLD or nutritional compromise.
   - ☐ f. Infant <2 y/o with CLD of prematurity and for the previous 6 months continues to require medical support with:
     - ☐ Chronic corticosteroid therapy
     - ☐ Diuretic therapy
     - ☐ Supplemental oxygen
   - ☐ g. Infant <2 y/o with Cystic Fibrosis that previously received SYNAGIS therapy for RSV season and one of the following
     - ☐ Previous hospitalization for pulmonary exacerbation in the first year of life
     - ☐ Chest computed tomography that persists when stable or abnormalities on chest adiography
     - ☐ Weight for length is less than the 10th percentile based on WHO growth chart
   - ☐ h. Infants <2 y/o who are profoundly immunocompromised
   - ☐ i. Infants <2 y/o who had a cardiac transplant during RSV season
   - ☐ j. Infants <2 y/o who continue to require prophylaxis after cardio-pulmonary by-pass or following the conclusion of extra-corporeal membrane oxygenation requiring a post-op dose as soon as the infant is medically stable (specify date) Date: _____
   - ☐ k. Other (please specify) _____

I certify that the above information is correct and accurate to the best of my knowledge and that the form is complete (please sign and date). I understand that I may be subject to civil penalties or criminal prosecutions for any falsification, omission, or concealment of any material fact contained herein.

PRESCRIBER'S SIGNATURE: _____ DATE: _____

FAX COMPLETED PA REQUEST FORM AND ALL NECESSARY DOCUMENTATION TO 1-866-535-7622

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