WellCare

NC Medicaid
Pharmacy Prior Approval Request for
Palivizumab (Synagis®)

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext._____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other _____

Clinical Information

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 0 days of gestation? ☐ YES ☐ NO
   Birth EGA: _____ Weeks: _____ Days: _____

Criteria for Infants less than 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 Diagnosis?
   - ☐ 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 less than 32 weeks 0 days gestation and requiring greater than 21% oxygen for at least first 28 days after birth)

****Please submit documentation of CLD as defined to meet criteria approval, e.g. NICU discharge summary**

Criteria for Infants less than 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 Diagnosis?
   - ☐ 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 less than10th percentile
   - ☐ 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

****Please submit documentation of CLD as defined to meet criteria approval, e.g. NICU discharge summary**

Fax this form to CSRA at (855) 710-1969 Pharmacy PA Call Center: (866) 246-8505

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NOTE: The provider should use the Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age 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 .

Signature of Prescriber:_____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

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