Drug Prior Authorization-
palivizumab (SYNAGIS)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Birth Date:	Prescriber Fax:

STEP 2: COMPLETE REQUIRED CRITERIA

☐ Primary Diagnosis: _____ICD 10 Code **(REQUIRED)**: _____

REQUIRED FOR ALL:

☐ Prescriber is an NICU Physician, Neonatologist or Pediatric Specialist (including Family Practice, General Pediatrics, Pediatric Pulmonology, Pediatric Cardiology)

☐ **DIAGNOSIS A:** < 29 weeks, 0 days gestational age at birth AND < 12 months old at the start of RSV season

Note: Max of 5 monthly doses or through end of RSV season

☐ **DIAGNOSIS B:** < 32 weeks, 0 days gestational age **AND** chronic lung disease of prematurity (Defined as >21% oxygen required for at least the first 28 days after birth) **AND** < 12 months old at the start of RSV season

Note: Max of 5 monthly doses or through end of RSV season

☐ **DIAGNOSIS C:** Age > 12 months and < 24 months, 0 days at the start of RSV season **AND** < 32 weeks, 0 days gestational age **AND** chronic lung disease of prematurity (> 21% oxygen required for at least the first 28 days after birth) **AND** continue to require medical support during the 6-month period prior to the start of the second RSV season (at least one of the following):

- ☐ chronic corticosteroid therapy: Describe therapy: _____
- ☐ diuretic therapy: Describe therapy: _____
- ☐ supplemental oxygen: Describe therapy: _____

Note: Max of 5 monthly doses or through end of RSV season

☐ **DIAGNOSIS D:** Severe congenital abnormality of airway **OR** severe neuromuscular disease that compromises handling of respiratory tract secretions **AND** < 12 months old at the start of RSV season

Note: Max of 5 monthly doses or through end of RSV season

☐ **DIAGNOSIS E:** Active diagnosis of hemodynamically significant heart disease (*Check one of the following conditions*) **AND** < 12 months old at start of RSV season

☐ CHF on medication ☐ Cyanotic heart disease

☐ Moderate to severe Pulmonary Hypertension

Note: Max of 5 monthly doses or through end of RSV season. **Exception: one extra dose may be administered after surgery requiring cardiopulmonary bypass or extracorporeal membrane oxygenation

The following groups of infants with CHD are not at increased risk of RSV and generally should not receive prophylaxis:

- Infants and children with hemodynamically insignificant heart disease to include secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus
- Infants with lesions adequately corrected by surgery, unless they continue to require medication for CHF
- Infants with mild cardiomyopathy who are not receiving medical therapy for this condition Children in the second year of life

☐ **DIAGNOSIS F:** Profoundly immunocompromised child (e.g., solid organ transplant, bone marrow transplant, or cancer chemotherapy) **AND** age < 24 months at the start of RSV season.

Note: Max of 5 monthly doses or through end of RSV season

STEP 3: SPECIALTY PHARMACY REQUIRED

☐ Avella Specialty Pharmacy

*****Please Complete the Specialty Medication Prescription Form on Page 3.***

STEP 4: SUBMISSION. SIGN AND FAX TO: PRIOR AUTHORIZATION **855-668-8551**

Prescriber Signature: _____ Date: _____

If patient meets criteria, please allow 2 business days for processing
If criteria not met, please submit chart documentation with form citing complex medical circumstances
If approved, coverage allowed as indicated above, subject to formulary changes
For questions, please call Navitus Customer Care at 1-866-333-2757

Reference:
Updated Guidance for Palivizumab Prophylaxis Among Infants and Young Children at Increased Risk of Hospitalization for Respiratory Syncytial Virus Infection. American Academy of Pediatrics. 2014

Specialty Medication Prescription Form

Fax completed Specialty Medication Request Form **AND** Prior Authorization Form to:

Prior Authorization, Fax Number: 855-668-8551

The Specialty Prescription Form will be forwarded if Prior Authorization is approved

PRESCRIBER INFORMATION	
Prescriber First & Last Name:	Prescriber NPI:
Prescriber Fax:	Prescriber Phone:
Office Contact / RN Name:	Prescriber Mailing Address:
PATIENT INFORMATION	
Please check one: ☐ **New Patient** ☐ **Refill Request**	
Patient First & Last Name:	Patient DOB:
Patient Daytime Phone:	Patient Home Phone:
Patient ID:	Group #:
Height:	Weight:
Primary Diagnosis:	Allergies:
SHIPPING INFORMATION	
Ship Medication to (please check one): ☐ **Home** ☐ **Other**	
Shipping Address (Street, City, State, Zip):	

PRESCRIPTION INFORMATION

Drug Name	**Strength**	**Instructions**	**Quantity**	**# of Refill(s)**	**Date Needed**

Prescriber Signature: _____ **Date:** _____