

**SYNAGIS (PALIVIZUMAB)
PRIOR AUTHORIZATION FORM**



This form must be completed by a person with thorough clinical knowledge of the member's current clinical presentation and his/her treatment history. The entire form must be completed as clearly and specifically as possible. Omissions, generalities, and illegibility will result in the form being returned for further completion or clarification. For more information, please refer to the medical policy document PC/S005 located at <https://www.preferredone.com/MedicalPolicy/>. **Please fax this form and other relevant documents to (763) 847-4014.**

Patient Name and ID#		Patient DOB	Date/s of Service
			Setting <input type="checkbox"/> Office <input type="checkbox"/> Home Health Care
Patient Gestational Age ____weeks ____days	Dx/ICD-10		CPT/HCPCS Code/s
Prescriber Name	Prescriber Phone		
NPI	Prescriber Fax	Prescriber Signature	
Pharmacy Name (if applicable)			
NPI	Pharmacy Phone	Pharmacy Fax	
Home Health Care Provider (HHC) Name (if applicable)			
NPI	HHC Phone	HHC Fax	

INDICATIONS - must have one of the following: A-F	Check Box
[Note: RSV season is based on regional seasonality of the disease. The RSV season in Minnesota is November 1 to March 31.]	
A. Gestational age less than 29 weeks 0 days who is less than 12 months of age at the beginning of the RSV season	
B. Chronic lung disease (CLD) of prematurity – must meet: 1, and either 2 or 3 1. Gestational age less than 32 weeks 0 days; and 2. Less than or equal to 12 months of age during the RSV season and requires greater than 21% oxygen for at least the first 28 days after birth; or 3. Between 13 to less than 24 months of age and required greater than 21% oxygen for at least the first 28 days after birth and still requires medical support (eg, chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) during the 6-month period before the start of the second RSV season.	
C. Member diagnosed with hemodynamically significant congenital heart disease (CHD) – must meet: 1 or 2 1. INITIAL REQUEST (covers up to 5 doses) Less than or equal to 12 months of age, born within 12 months of onset of the RSV season, with any of the following (check box if applicable): <input type="checkbox"/> Acyanotic heart disease with both of the following: • Member is receiving medication to control congestive heart failure; and • Member will require cardiac surgical procedures <input type="checkbox"/> Moderate to severe pulmonary hypertension <input type="checkbox"/> Cyanotic heart defects in the first year of life with documentation of decision for prophylaxis made in consultation with a pediatric cardiologist. 2. ONE ADDITIONAL DOSE REQUEST (> than 5 doses) Less than 24 months of age, the prescriber is requesting one additional postoperative dose of Synagis for prophylaxis, with any of the following (check box if applicable): <input type="checkbox"/> Member has undergone cardiac transplantation during the RSV season <input type="checkbox"/> Member has undergone cardiac bypass or after extracorporeal membrane oxygenation during the RSV season [Note: One additional dose will be approved if medically necessary.]	
D. Member diagnosed with anatomic pulmonary abnormalities or neuromuscular disorders – must meet: both 1 and 2 1. Less than 12 months of age; and 2. Anatomic pulmonary abnormalities (eg, pulmonary malformations, tracheoesophageal fistula, conditions requiring tracheostomy) or neuromuscular disorders (eg, cerebral palsy) impair the member's ability to clear secretions from the upper airway because of ineffective cough.	
E. Member is profoundly immunocompromised (eg, solid organ transplantation, hematopoietic stem cell transplantation, severe combined immunodeficiency syndrome) and is less than 24 months of age during the RSV season	
F. Member diagnosed with cystic fibrosis – must meet: 1 or 2 1. Less than 12 months of age with evidence of CLD and/or nutritional compromise; or 2. Between 12 to 24 months of age – and one of the following: a or b a. Manifestations of severe lung disease (ie, previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest radiography or chest computed tomography that persist when stable); or b. Weight for length that is less than the 10 th percentile on the pediatric growth chart	

DOSING			
Dose Requested: ____mg		Current Weight: ____kg	
		A dose of Synagis has been administered in an inpatient setting <input type="checkbox"/> YES – Indicate date dose was administered: ____ <input type="checkbox"/> NO	
Weight	Calculated Dose (max wt.)	Allowed Dose	Dispense (vials)
0 to 3.6kg	54mg	50mg	One 50mg
3.7 to 7.3kg	110mg	100mg	One 100mg
7.4 to 11.1kg	166.5mg	150mg	One 100mg and one 50mg
11.2 to 14. kg	220mg	200mg	Two 100mg
14.7 to 18.1kg	271.5mg	250mg	Two 100mg and one 50mg

[Note: The calculated dose of Synagis is 15mg/kg. This drug is available only in 50mg and 100mg vials and costs approximately \$1,000 per 50mg. To limit/minimize potentially significant waste, follow the table on the left, which shows a 10% difference in allowed dose from the calculated dose.]