Alaska Medicaid Prior Authorization Request Form

Synagis®

For RSV Season November 23, 2020 through May 15, 2021

Fax this request to: **1-888-603-7696** Questions: **Call Magellan Medicaid Administration at 800-331-4475**

Or mail this request to: **Medicaid PA Unit, 14100 Magellan Plaza, Maryland Heights, MO 63043**

If the following information is not complete, correct, or legible, the PA process can be delayed. Use one form per member, please.

Member Information

LAST NAME: **FIRST NAME:**

ID NUMBER: **DATE OF BIRTH:** – –

SEX: ☐ Male ☐ Female

Prescriber Information

LAST NAME: **FIRST NAME:**

NPI NUMBER:

PHONE NUMBER: – – **FAX NUMBER:** – –

Request

Synagis® 50 mg NDC 60574411401 QTY: _____ Requested Start Date: / /

Synagis® 100 mg NDC 60574411301 QTY: _____ Requested Start Date: / /

Rationale for Prior Authorization (http://dhss.alaska.gov/dhcs/Pages/pharmacy/medprioratuthoriz.aspx)

Gestational age: _____ **Weeks** _____ **Days** *Note: Weeks and days are both required.* **Weight in kilograms:** _____

☐ **Diagnosis of Chronic Lung Disease** (formerly called bronchopulmonary dysplasia) **AND** child must be < 24 months of age at onset of season on Nov. 23 (DOB after 11/23/2018) **AND** child has required medical treatment in the preceding 6 months. Check/Complete all that apply:

- ☐ Oxygen most recent date administered: ___ / ___ / _____
- ☐ Corticosteroids most recent date administered: ___ / ___ / _____
- ☐ Bronchodilators most recent date administered: ___ / ___ / _____
- ☐ Other – most recent date administered: ___ / ___ / _____

The child may be approved for no more than 5 monthly doses of palivizumab.

☐ **Hemodynamically significant cyanotic or acyanotic Congenital Heart Disease (CHD) AND** child must be ≤ 24 months of age at onset of season on November 23 (DOB on or after 11/23/2018). *The child may be approved for no more than 5 monthly doses of palivizumab. If the child undergoes cardio-pulmonary bypass surgery during the RSV season, an extra post-operative dose can be authorized.*

- ☐ Cardio-pulmonary bypass surgery; Date: ___ / ___ / _____

☐ **Child is** < **12 months of age on November 23** (DOB after 11/23/2019); **AND**

- ☐ Gestational age ≤ 28 weeks, 6 days; **OR**

☐ **Child is** < **12 months of age on November 23** (DOB after 11/23/2019) **AND** diagnosed with:

- ☐ Congenital abnormalities of the airway; **OR**
- ☐ Neuromuscular condition requiring handling of respiratory secretions. *The child may be approved for no more than 5 monthly doses of palivizumab.*

☐ **Child is** < **6 months of age on Nov. 23 (**DOB after 5/23/2020) **AND** gestational age is 29 weeks, 0 days through 31 weeks, 6 days. *The child may be approved for no more than 5 monthly doses of palivizumab.*

☐ **Child is < 3 months of age on Nov. 23** (DOB on 8/25/2020 or after) **AND** gestational age is 32 weeks, 0 days through 34 weeks, 6 days, **AND:**

- ☐ Child attends daycare; **OR**
- ☐ Child resides in a home with another child < 5 years of age; **OR**
- ☐ Child resides in a crowded living environment (≥ 3 children per bedroom or ≥ 7 people per household); **OR**
- ☐ Child resides in a home with lack of running water.

*The child in this category will qualify for monthly doses **only** up until 3 months (90 days) of age.*

Prescriber's Signature _____ ***Date:*** _____

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