REALRx

PRIOR AUTHORIZATION REQUEST FORM
SYNAGIS®

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Gestational Age at Birth (give weeks & days):		Member Weight:

Product being requested: ☐ Synagis® (palivizumab)

Dosing/Frequency:_____

Please note:
Requests may be approved for up to a maximum of 4 to 5 doses at a dosing interval of not less than 28 days between injections.
Requests will only be authorized for treatment during the State Health Department's declared official Synagis® season.
Approved requests will be authorized to start on the first date of the official Synagis® season.
If the member has tested positive for RSV, further requests for Synagis® will not be approved.

Questions	Yes	No	Comments/Notes
1. Is this request for an **expedited** review? By checking the **"Yes"** box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	☐	☐	
2. Was the member's age ≤ 12 months at the start of the RSV season? If no, skip to question #7.	☐	☐	
3. If the member is < 6 months of age, is Beyfortus (nirsevimab) available for administration?	☐	☐	
4. Was the member born before 29 weeks, 0 days gestation? *Note: Synagis prophylaxis is not recommended for otherwise well infants ≥ 29 weeks gestational age.*	☐	☐	
5. Was the member diagnosed with chronic lung disease of prematurity, defined as gestational age < 32 weeks AND required supplemental oxygen for at least the first 28 days after birth?	☐	☐	
6. Is the member diagnosed with hemodynamically significant congenital heart disease with one of the following: • Cyanotic heart disease, receiving medication to control congestive heart failure?; OR • Member will require cardiac surgical procedures?; OR • Member has moderate to severe pulmonary hypertension? *Note: Synagis® prophylaxis is not recommended for infants with hemodynamically insignificant heart disease, such as secundum atrial*	☐	☐	

septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, or patent ductus arteriosus.			
7. Does the member have anatomic pulmonary abnormalities or neuromuscular disorders that impairs the ability to clear secretions from the upper airway?	☐	☐	
8. Will the member be profoundly immunocompromised during the respiratory syncytial virus (RSV) season?	☐	☐	
9. Was the member's age ≥ 12 months and <24 months at the start of the RSV season?	☐	☐	
10. Is the member <20 months and expected to receive a heart transplant during the current RSV season?	☐	☐	
11. Is the member <20 months and expected to be profoundly immunocompromised during the current RSV season?	☐	☐	
12. Was the member born at less than 32 weeks 0 days gestation and required at least 28 days of oxygen after birth and continues to require medical intervention with supplemental oxygen, chronic corticosteroids, or diuretic therapy in the 6 months prior to the start of the current RSV season? *Note: Synagis prophylaxis is not recommended for otherwise well infants with chronic lung disease of prematurity who are 12 to 24 months old.*	☐	☐	
13. Has the member had a respiratory syncytial virus-related hospitalization during this RSV season?	☐	☐	
14. Has the member received Beyfortus during this RSV season?	☐	☐	
15. Was Synagis® given while the member was in the hospital (e.g., NBICU, NICU)? If yes, please list dates given: _____	☐	☐	
Physician's Signature:			

** Failure to submit clinical documentation to support this request will result in a dismissal of the request.**

1. **Synagis® (palivizumab) therapy is authorized according to current guidelines for treatment of RSV as published by the American Academy of Pediatrics Committee on Infectious Diseases; American Academy of Pediatrics Bronchiolitis Guidelines Committee. The current guidelines may be found online at** http://pediatrics.aappublications.org/content/pediatrics/134/2/415.full.pdf.
2. **Synagis® injections may be authorized during the RSV season, as defined by the local State Department of Health.**
3. **Up to 4-5 monthly doses may be authorized. Infants born during the RSV season, and who are approved for Synagis® therapy, may receive monthly doses until end date determined by the local State Health Department.**
4. **Synagis® therapy will not be approved with active RSV infection.**
5. **Synagis® prophylaxis will be discontinued if the member is hospitalized for RSV infection while being treated with monthly prophylaxis.**
6. **Synagis® therapy will be provided by the preferred pharmacy vendor.**
7. **Synagis® season information is available on the CDC website:** https://www.cdc.gov/surveillance/nrevss/rsv/state.html

Policy: PHARM- 073
Origination Date: 10/19/2014
Reviewed/Revised Date: 09/18/2024
Next Review Date: 09/18/2025
Current Effective Date: 10/01/2024