GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Synagis® Prior Authorization Request Form (Page 1 of 3)

MUST BE COMPLETED BY PHYSICIAN AND FAXED TO OPTUMRX AT 1-888-491-9742

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if member has **received Beyfortus (nirsevimab)**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Medical criteria:

Gestational Age: _____ Weeks _____ Days Birth Weight: _____ g/kg/lbs

Current Weight: _____ kg/lbs Date Recorded:____/ ____/_____

Please Document All Diagnoses to the Highest Degree of ICD-10 Detail

1. Prematurity: ❑ Yes ❑ No Weeks of Gestation ICD-10: _____

❑ Gestational Age of < 29 Weeks (P07.21 – P07.26, P07.31) ❑ < 12 Months of Age at Start of RSV Season

❑ Gestational Age of 29 to < 32 Weeks (P07.32 – P07.34) ❑ < 24 Months of Age at Start of RSV Season

2. Chronic Lung Disease (CLD) of Prematurity (<32 Weeks' Gestation) AND < 24 Months of Age at Start of RSV Season: ❑ Yes ❑ No

❑ Chronic Respiratory Disease Originating in the Perinatal Period ICD-10 Code(s): _____

❑ Other Diagnosis (If Applicable) _____ ICD-10 Code(s): _____

Did the patient require oxygen for first 28 days after birth? ❑ **Yes** ❑ **No**

If **Yes**, what % oxygen was required? _____

Did the patient receive medical support during 6-month period before start of RSV season? ❑ **Yes** ❑ **No**

If **Yes**, select all that apply and provide last date received:

❑ Corticosteroid Last date received: ____/ ____/_____

❑ Diuretic Last date received: ____/ ____/_____

❑ Oxygen Last date received: ____/ ____/_____

3. Hemodynamically Significant Congenital Heart Disease (CHD) AND < 12 Months of Age at Start of RSV Season: ❑ Yes ❑ No

❑ CHD (Please specify): _____ ICD-10 Code(s):_____

❑ Other Diagnosis (If Applicable) _____ ICD-10 Code(s):_____

Select if the patient has the following conditions (Check all that apply):

❑ Acyanotic CHD

❑ Moderate-Severe Pulmonary Hypertension

❑ Cyanotic CHD

If the patient has cyanotic CHD, please provide:

Pediatric Cardiologist: _____ Office #: _____

Medications for CHF: _____ Last Date Received: ____/ ____/_____

Did the patient have any cardiac surgical procedure(s)? ❑ **Yes** ❑ **No**

If **Yes**, describe the cardiac surgical procedure(s): _____

_____

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4. Profoundly Immunocompromised AND < 24 Months of Age at Start of RSV Season: ❑ Yes ❑ No

❑ Bone Marrow Transplant
❑ Neoplasm Receiving Chemotherapy (Please specify): _____ ICD-10 Code(s):_____
❑ Severe Immunodeficiency (Please specify): _____ ICD-10 Code(s):_____
❑ Solid Organ Transplantation (Please specify): _____ ICD-10 Code(s):_____
❑ Stem Cell Transplant
❑ Other Diagnosis (If Applicable) _____ ICD-10 Code(s):_____

5. Pulmonary Abnormality or Neuromuscular Disorder that Impairs Ability to Clear Secretions from Upper Airways AND <12 months of Age at Start of RSV Season: ❑ Yes ❑ No

❑ Congenital Pulmonary Abnormality (Please specify): _____ ICD-10 Code(s):_____
❑ Neuromuscular Disorder (Please specify): _____ ICD-10 Code(s):_____
❑ Other Pulmonary Abnormality (Please specify): _____ ICD-10 Code(s):_____

Does the patient have ineffective cough? ❑ **Yes** ❑ **No**

6. Cystic Fibrosis (CF) and < 24 Months of Age at Start of RSV Season: ❑ Yes ❑ No

❑ Cystic Fibrosis (Please specify): _____ ICD-10 Code(s):_____

OTHER RELEVANT MEDICAL HISTORY:

NICU History: ❑ Yes ❑ No NICU Name: _____
If Yes, please attach the NICU discharge summary
Was there a NICU dose administered? ❑ **Yes** ❑ **No**
If **Yes**, provide the date: ____/ ____/_____
Did the neonatologist recommend Synagis prior to discharge? ❑ **Yes** ❑ **No**
Expected date of first/next injection: ____/ ____/_____

Previous health plan/insurance history:
Was dose administered in previous health plan? ❑ **Yes** ❑ **No**
If **Yes**, provide # of doses: _____ and last date received: ____/ ____/_____
Name of previous health plan: _____ Phone #: _____

Prescription Information:
❑ **Synagis (palivizumab)** 50 and/or 100 mg Vials ❑ No known drug allergies (NKDA)
Sig: Inject 15 mg/kg IM One Time Every 28 – 32 days
Dispense Quantity: QS ❑ Refill _____Months
Product to be administered in: ❑ Office ❑ Home Agency Nurse to Visit Home for Injection? ❑ **Yes** ❑ **No**
If the medication is to be administered in physician's office, does the prescriber certify that the medication will be shipped directly to their office from the pharmacy? ❑ **Yes** ❑ **No**
If to be administered in physician's office, please list name and address of pharmacy dispensing the medication:

Dispensing Pharmacy Name: _____
Address: _____
City: _____
State: _____ **Zip Code:** _____

If to be administered in member's home, please list name and address of pharmacy dispensing the medication AND name and address of the home health agency administering the medication:

Dispensing Pharmacy Name: _____
Address: _____
City: _____
State: _____ **Zip Code:** _____

Home Health Agency Name: _____
Address: _____
City: _____
State: _____ **Zip Code:** _____

Was dose previously administered in the office? ❑ **Yes** ❑ **No** # of Doses_____ Last Date Received: ____/ ____/_____
❑ Other: _____

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Prescriber's Signature (required): _____ **Date**:_____

(Must be signed by the physician. Stamped signature not allowed.)

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

_____

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_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-866-525-5827.
This form may be used for non-urgent requests and faxed to 1-888-491-9742.