VERMONT
Department of Vermont Health Access
NOB 1 South, 280 State Drive
Waterbury, Vermont 05671-1010

~Synagis PA ~

Prior Authorization Request Form

In order for members to receive Medicaid coverage for medications that require prior authorization, the prescriber must complete and fax this form to Change Healthcare. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information. For questions, please contact the Change Healthcare helpdesk at 1-844-679-5363.

Submit request via Fax: 1-844-679-5366

Prescribing physician:
Name: _____
Physician NPI: _____
Specialty: _____
Phone#: _____
Fax#: _____
Address: _____
Contact Person at Office: _____

Beneficiary:
Name: _____
Medicaid ID#: _____
Date of Birth: _____ Sex: _____
Patient's Phone: _____
Pharmacy Name_____
Pharmacy NPI: _____
Pharmacy Phone: _____Pharmacy Fax: _____

The following MUST be completed for MEDICAL BENEFIT requests:
CPT code(s): _____
Administering Provider/Facility: Name_____NPI#_____Medicaid ID#_____
Contact person at facility: _____ Phone # _____ Fax number: _____

Gestational Age: _____ Weeks ____ Days Current Weight: _____(kg) Dose: _____ 15mg/kg (verified monthly)

Diagnosis (please submit supporting clinical documentation):

☐ Infants born at 28 weeks of gestation or earlier (i.e., ≤ 28 weeks, 6 days) and under 12 months of age at the start of the RSV season (maximum 5 doses)

☐ Infants born at 29-32 weeks (i.e., between 29 weeks, 0 days and 31 weeks, 6 days) of gestation and under 1 year of age at the start of the RSV season who develop chronic lung disease of prematurity defined as a requirement for >21% oxygen for at least the first 28 days after birth (maximum 5 doses)

☐ Children under 24 months of age who will undergo a heart transplant during the RSV season (maximum 5 doses)

☐ Children under 24 months of age who are profoundly immunocompromised during the RSV season (e.g. undergoing organ or hematopoietic stem cell transplant or receiving chemotherapy) (maximum 5 doses)

☐ Children under 24 months of age with chronic lung disease of prematurity defined as born at 31 weeks, 6 days or less who required >21% oxygen for at least the first 28 days after birth and continue to require medical support (chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) during the 6- month period before the start of the second RSV season (maximum 5 doses).

Treatment: _____Dates of Use: _____

☐ Children under 12 months of age with hemodynamically significant congenital heart disease (CHD) (dosing continues in the RSV season through the end of the month the infant reaches 12 months old -maximum 5 doses)

- ☐ Acyanotic heart disease and receiving medication to control congestive heart failure and will require cardiac surgical procedure
- ☐ Moderate to severe pulmonary hypertension
- ☐ Cyanotic heart disease and recommended for Synagis therapy by Pediatric Cardiologist

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☐ Infants under 12 months of age with either: (dosing continues in the RSV season through the end of the month the infant reaches 12 months old – maximum 5 doses)

- ☐ Congenital abnormalities of the airways that impairs the ability to clear secretions from the upper airway because of ineffective cough
- ☐ Neuromuscular condition that impairs the ability to clear secretions from the upper airway because of ineffective cough

☐ Other: _____

NICU HISTORY

Did the patient spend time in the NICU?

☐ Yes ☐ No (If yes, please attach the NICU summary)

Was RSV prophylaxis recommended by the NICU/Hospital physician for this patient?

☐ Yes ☐ No

Was a NICU/Hospital /Clinic dose administered?

☐ Yes, Date(s): _____

PRESCRIPTION

Synagis (palivizumab) 50 and/or 100 mg vials and supplies for administration.

Sig: Inject 15 mg/kg IM once every 4 weeks; expected date of first home injection: _____
Dispense Quantity: Quantity sufficient for prophylaxis thru 04/2024

Deliver product to: ☐ MD office ☐ Patient's home ☐ Clinic

☐ Home health nurse to administer injection Home Health Agency: _____
If delivery is to clinic, please give location:

Pediatric Anaphylaxis: Administer 0.01 ml/kg (max 0.3ml) of 1:1000 epinephrine solution subcutaneously or intramuscularly, and contact EMS as appropriate.

Other:_____
Sig: _____

BEYFORTUS™ ATTESTATION

☐ The member has not already received Beyfortus™ (Nirsevimab-alip) for the current RSV season. **Note:** Concomitant use with Beyfortus™ will not be approved.

Physician will monitor patient's response to therapy. Any complications in therapy will be reported to the physician either by the patient's caregiver or the skilled nursing service. Requests for dose changes resulting from weight gain must be submitted to Change Healthcare via fax: 844-679-5366.

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

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