



**Montana Medicaid Prior Authorization Request Form for Use of Synagis® (palivizumab)**

Patient's Name: \_\_\_\_\_ Patient's Medicaid ID #: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Physician's Phone #: \_\_\_\_\_ Physician's Fax #: \_\_\_\_\_

**Estimated Gestational Age (EGA) at time of birth:** \_\_\_\_\_

**Was Synagis® previously administered? (Hospital/NICU/other) No Yes Date(s):** \_\_\_\_\_

**Expected date of first/next dose:** \_\_\_\_\_

**Current weight of child at time of request:** \_\_\_\_\_

**Requirements:** (Please check all that apply and submit any additional supporting documentation)

1. Patient age at onset of RSV season is <12 months (does not include 1<sup>st</sup> birthday) AND any of the following:

- Estimated Gestational Age (EGA) <29 weeks
- EGA < 32 weeks with a diagnosis of chronic lung disease (CLD) in the past 12 months and history of requirement for 21% oxygen for the first 28 days after birth
- Diagnosis of hemodynamically significant acyanotic congenital heart disease in the past 12 months AND history of drugs to treat CHF or moderate to severe pulmonary hypertension in the past 45 days
  - Please list diagnosis, medications, and dates taken:
- Diagnosis of hemodynamically significant cyanotic congenital heart disease in the past 12 months AND prescriber is a pediatric cardiologist OR a pediatric cardiologist consult is attached.
- Diagnosis of severe neuromuscular disease or congenital respiratory abnormalities (does not include CF) in the past 12 months
- Patient undergoing cardiac transplantation OR patient is profoundly immunocompromised (e.g. stem cell or organ transplant, chemotherapy, etc) during RSV season
  - Date of expected cardiac transplant: \_\_\_\_\_
  - Explanation of immunocompromised status:

2. Patient age at onset of RSV season is <24 months (does not include 2<sup>nd</sup> birthday) AND any of the following:

- Diagnosis of chronic lung disease (CLD) in the past 2 years WITH history in past 6 months of O2 supplementation, bronchodilators, diuretics, or 3 or more claims for systemic or inhaled corticosteroids
  - O2 supplementation start date: \_\_\_\_\_ stop date: \_\_\_\_\_
  - Please list medications and dates taken:
  
- Patient undergoing cardiac transplantation OR patient is profoundly immunocompromised during RSV season
  - Date of expected cardiac transplant: \_\_\_\_\_
  - Explanation of immunocompromised status:

### **Limitations:**

1. The 2014-15 season for Montana Medicaid RSV prophylaxis will run from December 15, 2014 through April 30, 2015.
2. Approval will be for 1 dose per month up to a maximum of 5 doses during the RSV season.
3. Medicaid will allow one 50mg vial (0.5ml) OR one 100mg (1ml) vial. Doses above 100mg will require prior authorization based on patient weight.

**Please complete form, attach supporting documentation, and fax to:  
Medicaid Drug Prior Authorization Unit at 1-800-294-1350**