Gateway Health℠ It's Wholecare.

Updated: 07/2021
PARP Approved: 07/2021

Prior Authorization Criteria

**Synagis (palivizumab)**

All requests for Synagis (palivizumab) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Coverage may be provided with a diagnosis of prevention of Respiratory Syncytial Virus (RSV) and the following criteria is met:

- A 5 month maximum duration with an authorization not to exceed March 31st:
- The member must be a pediatric member determined to be at high-risk for RSV.
    - High Risk is considered one of the following:

        - Infants < 29 weeks, 0 days gestational at birth and < 12 months of age on the start of the RSV season

        - Infants with Chronic Lung Disease of prematurity, defined as having been < 32 weeks, 0 days gestational at birth, and < 12 months of age on the start of the RSV season with a > 21% oxygen requirement for at least 28 days after birth

        - Infants < 12 months of age on the start of the RSV season with a congenital abnormality of the airway or neuromuscular condition that compromises respiratory secretion clearance

        - Infants < 12 months of age on the start of the RSV season and diagnosed with hemodynamically significant Congenital Heart Disease (i.e. receiving medications to control HF and will require cardiac surgical procedures or with moderate to severe pulmonary hypertension or with acyanotic heart disease or with cyanotic heart disease when a cardiologist has been consulted)

        - Infants < 12 months of age on the start of the RSV season with Cystic Fibrosis and clinical evidence of Chronic Lung Disease (CLD) requiring medical therapy or nutritional compromise as per the AAP guidelines

        - Infants < 2 years of age at the time of request who had CLD of prematurity and has continued to require medical therapy (supplemental oxygen, bronchodilator, diuretic, or corticosteroid therapy) for CLD within the past 6 months

- Infants < 2 years of age at the time of request with CHD and who have received a heart transplant during the RSV season

- Infants < 2 years of age at the time of request and are profoundly immunocompromised as defined by receiving chemotherapy or received an organ or stem cell transplant

- Infants < 2 years of age at the time of request with Cystic Fibrosis and with risk factors as per the AAP guidelines (i.e. weight for length < 10$^{th}$ percentile, abnormalities on chest radiography or chest computed tomography that persist when stable, previous hospitalization for pulmonary exacerbation in the first year of life)

**Initial Duration of Approval:** A 5 month maximum duration with an authorization not to exceed March 31$^{st}$:

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

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# SYNAGIS (PALIVISUMAB) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway Health℠ Pharmacy Services. **FAX:** (888) 245-2049

If needed, you may call to speak to a Pharmacy Services Representative.

**PHONE**: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

## PROVIDER INFORMATION

| | |
|---|---|
| Requesting Provider: | NPI: |
| Provider Specialty: | Office Contact: |
| Office Address: | Office Phone: |
| | Office Fax: |

## MEMBER INFORMATION

| | |
|---|---|
| Member Name: | DOB: |
| Gateway ID: | Member weight: _____pounds or _____kg |

## REQUESTED DRUG INFORMATION

| | |
|---|---|
| Medication: | Strength: |
| Frequency: | Duration: |
| Is the member currently receiving requested medication? ☐ Yes ☐ No | Date Medication Initiated: |

## Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

## Place of Service Information

| | |
|---|---|
| Name: | NPI: |
| Address: | Phone: |

## MEDICAL HISTORY (Complete for ALL requests)

**Gestational age:_____**

**Primary Diagnosis Code: _____ Additional Diagnosis Codes:**

**_____**

(additional diagnosis and supporting documentation is required for any child over 29 weeks)

**Was the first dose administered in the hospital?** ☐ No ☐ Yes (date administered)_____

(dose administered)_____

**Is the member's age 12 months of age or less as of start of RSV season:** ☐ No ☐ Yes

**Does the member have hemodynamically significant heart disease?** ☐ No ☐ Yes

**Has or will the member require a cardiac surgical procedure?** ☐ No ☐ Yes

Procedure:_____ Date of procedure:_____

**Has a cardiologist been consulted?** ☐ No ☐ Yes (please provide consultation recommendation)

☐ Moderate to severe pulmonary hypertension:

☐ Acyanotic heart disease. Diagnosis:_____

☐ Cyanotic heart disease: Diagnosis:_____

☐ Receiving medications to control CHF. Provide medications, dose, and dates of administration below:

_____
_____

**Does the member have chronic lung disease?** ☐ No ☐ Yes

**Was oxygen required at birth?** ☐ No ☐ Yes Provide percentage: _____Provide duration:_____

**Were medications used to treat chronic lung disease in the past 6 months?** ☐ No ☐ Yes (provide detail below)

☐ Supplemental O2: _____

☐ Bronchodilator(s): _____

☐ Diuretic(s): _____

☐ Corticosteroid(s): _____

**Additional risk factors:** Please check all that apply and provide requested information on space provided.

☐ Compromised respiratory secretion clearance due to:

☐ Congenital abnormality of the airway. Diagnosis:
_____

☐ Neuromuscular condition. Diagnosis:
_____

☐ Profoundly immunocompromised.
Diagnosis:_____

☐ Receiving chemotherapy. Provide therapy regimen:_____

☐ Received organ or stem cell transplant. Provide procedure date-_____

☐ Cystic fibrosis and clinical evidence of Chronic Lung Disease requiring medical therapy or nutritional compromise as per the AAP guidelines. Submit supporting documentation.

| **SUPPORTING INFORMATION or CLINICAL RATIONALE** | |
|---|---|
| | |
| | |
| | |
| **Prescribing Provider Signature** | Date |
| | |