AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Synagis

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: **Synagis** 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days ___Other:_____
12. Date of most recent administered dose: _____ ☐N/A 13. Most recent documented weight: _____

Clinical Information

1. Was the beneficiary administered Beyfortus during the current Synagis season? Yes___ No___
2. Was the maternal vaccine, Abrysvo, administered to the mother during pregnancy? Yes___ No___
3. Is Synagis being requested outside of policy criteria or outside of the defined coverage period (i.e. more than 5 doses)? Yes___ No___

If yes, please provide documentation as to why the beneficiary requires administration outside of the policy criteria.

If "Yes" to any question above, use the Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age. Do not use this Synagis PA form.

This is the beneficiary's ☐ first RSV season ☐ second RSV season

Criteria for Infants younger than 12 months *AND* in their *FIRST* RSV season

1. Was the beneficiary born premature before 29 weeks, 0 days of gestation? Yes___ No___
   Birth EGA: _____ Weeks: _____ Days: _____

Criteria for Infants less than 24 months of age *AND* in their *FIRST* RSV Season with one of the following diagnoses

2. Does the beneficiary have one of the following Diagnosis?
   - ☐ Hemodynamically significant acyanotic heart disease (CHD), receiving medication to control congestive heart failure, and will require cardiac surgical procedures
   - ☐ Moderate to severe pulmonary hypertension
   - ☐ Neuromuscular disease or pulmonary abnormality that impairs the ability to clear secretions from the upper airways because of ineffective cough
   - ☐ Cyanotic heart disease, with cardiologist recommendation. **Submit documentation of cardiologist recommendation.**
   - ☐ Cystic Fibrosis with clinical evidence of CLD and/or nutritional compromise
   - ☐ Profoundly immunocompromised during RSV season
   - ☐ Undergoing cardiac transplantation during RSV season
   - ☐ Chronic Lung Disease (CLD) of prematurity (defined as birth at less than 32 weeks 0 days gestation and requiring greater than 21% oxygen for at least the first 28 days after birth)
     ****Please submit documentation of CLD as defined to meet criteria approval, e.g. NICU discharge summary**

Criteria for Infants less than 24 months of age *AND* in their *SECOND* RSV season with one of the following diagnoses

3. Does the beneficiary have one of the following Diagnosis?
   - ☐ Profoundly immunocompromised during RSV season
   - ☐ Cardiac transplantation during RSV season
   - ☐ Cystic Fibrosis with manifestations of severe lung disease (previous hospitalization for pulmonary exacerbation in first year or abnormalities on chest radiography or chest computed tomography that persist when stable) or weight-for-length less than 10th percentile
   - ☐ CLD of prematurity (see above definition) and continue to require medical support supplemental oxygen, chronic corticosteroid or diuretic therapy during the six-month period before start of ***SECOND*** RSV season
     Indicate Treatment(s) for CLD:
     ☐ chronic corticosteroid therapy ☐ diuretic therapy ☐ supplemental oxygen ☐ no medical support required
     ****Please submit documentation of CLD as defined to meet criteria approval, e.g. NICU discharge summary**

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406