Excellus

Specialty Medication Review Program

Synagis® (palivizumab) for
Respiratory Syncytial Virus (RSV) Prophylaxis
Medical Benefit

Complete this form and fax to:

Medical Specialty Unit
Fax #: 1-800-306-0188
Phone #: 1-800-499-1275

If you are not **buying and billing** this medication, indicate which specialty pharmacy will be used:

☐ **Accredo Health**
Fax #: 1-888-773-7386
Phone #: 1-866-413-4137

☐ **Buy and Bill**

Complete ALL the following Patient/Prescriber Information: (Please Print)

Patient Information	
Patient Name:	Patient Phone #: ( )
Patient ID #:	Patient Birthdate:
Secondary Insurer: (Name, Phone, ID #):	
List Patient Allergy (If Any)	
Prescriber Information	
Prescriber Name:	Prescriber Specialty:
Prescriber Address:	
Prescriber Phone #:	Prescriber Fax #:
Prescriber NPI #:	Office Contact: Extension:

Location of Infusion:

☐ **Prescriber office** ☐ **Home/Homecare agency:**_____

☐ **Outpatient facility** ☐ **Other:** _____

Servicing Prescriber NPI (if different from the ordering prescriber):

Provide address of infusion location above for medication shipping:

Medication/Medical and Dispensing Information

Medication (HCPCS)	**Dose & Frequency**	**Height**	**Current Weight & Date** (lbs./kgs)	**Procedure Code**
Synagis (90378)	Inject 15mg/kg IM once a month (Including ancillary supplies)	_____ inches	_____ / _____	

*Maximum 4 refills. Refills after April 1st of the Synagis Season will require additional prior approval.

1. Birth weight: lbs. _____ kgs: _____ 2. Gestational Age: Weeks: _____ Days: _____

3. Diagnosis/ICD-10:

4. Indications of Medical Necessity: _____

Questions/Indications for Medical Necessity

**** See the Synagis (Palivizumab) Policy (Pharmacy-51) for full Prior Authorization criteria ****

***Note:** All requests for RSV Prophylaxis will be required to use Beyfortus unless there is a medical reason why Beyfortus cannot be used and/or there is an ability to acquire Beyfortus. Beyfortus is covered without Prior Authorization.

1. Does this patient have a medical reason why they cannot use Beyfortus? *If yes, please explain the medical reason why Beyfortus cannot be used: _____	☐ **YES** ☐ **NO**
2. Has there been an inability to acquire Beyfortus? *If yes, please explain: _____	☐ **YES** ☐ **NO**

(Complete Only One Box Which Best Describes Your Patient)

1. Infants born prematurely	
a. Was the patient born at 29 weeks or less gestation age? b. **AND** will the patient be less than 12 months chronological age at season start	☐ **YES** ☐ **NO**
2. Congenital Heart Disease (CHD): **Provide recent cardiologist notes**	
a. Does the patient have hemodynamically significant congenital heart disease treated by a cardiologist? b. Diagnosis: _____ c. Medications: _____ d. Surgical Procedure Required? *If yes, specify: _____ e. **AND** will the patient be 12 months or less at season start?	☐ **YES** ☐ **NO** ☐ **YES** ☐ **NO**
3. Immunocompromised:	
a. Is the patient immunocompromised due to: ☐ Stem cell transplant (BMT, peripheral blood or cord blood) and less than 2 years old ☐ Lung transplant and less than 2 years old ☐ Severe combined immunodeficiency less than 2 years old ☐ Any other severe immunodeficiency less than 2 years old? *If yes, specify:_____	☐ **YES** ☐ **NO** ☐ **YES** ☐ **NO**

Continue onto the next page

Excellus

Synagis® (palivizumab)
Respiratory Syncytial Virus (RSV) Prophylaxis
Medical Benefit

4. Neuromuscular disorder	
☐ Severe **neuromuscular disorders AND** ☐ Compromising handling of respiratory secretions **AND** ☐ Less than 12 months of age at season start	
5. Pulmonary abnormalities	
☐ Significant Congenital abnormalities of the airways **AND** ☐ Compromising handling of respiratory secretions **AND** ☐ Less than 12 months of age at season start	
6. Cystic Fibrosis (CF)	
☐ Child < 12 months at start of RSV season with diagnosis of CF **AND** nutritional compromise ☐ Child < 12 months at start of RSV season with chronic lung disease of prematurity • Was the patient born at 32 gestational weeks or less? • Did the patient require >21% Oxygen for at least the first 28 days of birth?	☐ **YES** ☐ **NO** ☐ **YES** ☐ **NO**
7. Second Season Request	
☐ Child < 24 months at start of RSV season with diagnosis of CF **AND** weight less than the 10th percentile ☐ Child < 24 months at start of RSV season with diagnosis of CF **AND** manifestations of severe lung disease • Has this patient had previous hospitalization for pulmonary exacerbation in the 1st year of life? • Has this patient had abnormalities on chest radiography or chest CT that persist when stable?	☐ **YES** ☐ **NO** ☐ **YES** ☐ **NO**
Provide Other Comments/Clinical Justification:	

***ATTACH ANY CLINICAL NOTES RELATED TO THIS REQUEST. IF DOCUMENTATION IS NOT PROVIDED, IT MAY DELAY THE REQUEST**

*Prescriber Signature: _____ Date: _____

I certify the above is true and accurate to the best of my knowledge.