Print Reset

Alaska Medicaid

Synagis® Prior Authorization Form

For RSV Season: November 18, 2024–May 15, 2025

This form may also be used for requests to exceed the maximum allowed units.
Form available on Alaska Medicaid's Medication Prior Authorization website

Fax this form to 888-603-7696

This authorization request does not ensure eligibility and is not a guarantee of payment. Please verify Medicaid eligibility before completing this form. Incomplete requests will be denied until all required information is received.

Request Date: _____

REQUESTER INFORMATION

Requester Name: _____ Title: _____

MEMBER INFORMATION

Member Last Name: _____

Member First Name: _____

Member ID: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female Member Phone: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Prescriber NPI: _____ Specialty: _____

Prescriber Phone: _____ Prescriber Fax: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

DRUG INFORMATION

Drug Name: **Synagis**

Drug Strength: (Choose one.)

☐ 50 mg (NDC: 60574411401 or 66658023001)

☐ 100 mg (NDC: 60574411301 or 66658023101)

Quantity: _____ Requested Start Date: _____

Member's Name (Last, First): _____

CLINICAL INFORMATION

1. **Gestational Age**: _____ weeks _____ days (Note: Weeks and days are both required)
2. **Weight** (in kilograms): _____ kg
3. For coverage of Palivizumab, an attestation of the necessity of palivizumab over nirsevimab is required along with the rationale (e.g., lack of availability).

   ☐ Prescriber attests to necessity of palivizumab over nirsevimab.

   Rationale:

4. Check all that apply:

   a. ☐ Diagnosis of **Chronic Lung Disease** (formerly called bronchopulmonary dysplasia) **and** child must be < 24 months of age at onset of season on November 18 (DOB after November 18, 2022) **and** child has required medical treatment in the preceding 6 months.

      Check/complete all that apply:

      ☐ **Oxygen**
      Most Recent Date Administered: _____

      ☐ **Bronchodilators**
      Most Recent Date Administered: _____

      ☐ **Corticosteroids**
      Most Recent Date Administered: _____

      ☐ **Other**
      Most Recent Date Administered: _____

      Note: The child may be approved for no more than 5 monthly doses of palivizumab.

   b. ☐ Diagnosis of **Hemodynamically Significant Cyanotic or Acyanotic Congenital Heart Disease (CHD) and** child must be ≤ 24 months of age at onset of season on November 18 (DOB on or after November 18, 2022).

      Note: The child may be approved for no more than 5 monthly doses of palivizumab. If the child undergoes cardio-pulmonary bypass surgery during the RSV season, an extra post-operative dose can be authorized.

      ☐ **Cardio-pulmonary Bypass Surgery**

      Date Of Surgery: _____

   c. ☐ **Child is < 12 months of age on November 18** (DOB after November 18, 2023) **and** gestational age is ≤ 28 weeks, 6 days; **Or**

Member's Name (Last, First): _____

CLINICAL INFORMATION *(CONTINUED)*

d. ☐ **Child is < 12 months of age on November 18** (DOB after November 18, 2023) **and** diagnosed with the following:

☐ Congenital abnormalities of the airway; **Or**

☐ Neuromuscular condition requiring handling of respiratory secretions.

Note: The child may be approved for no more than 5 monthly doses of palivizumab.

e. ☐ **Child is < 6 months of age on November 18** (DOB after May 18, 2024) and gestational age is 29 weeks, 0 days through 31 weeks, 6 days.

Note: The child may be approved for no more than 5 monthly doses of palivizumab.

f. ☐ **Child is < 90 days of age on November 18** (DOB on August 19, 2024 or after) and gestational age is 32 weeks, 0 days through 34 weeks, 6 days; **And**

☐ Child attends daycare; **Or**

☐ Child resides in a home with another child < 5 years of age; **Or**

☐ Child resides in a crowded living environment (≥ 3 children per bedroom or ≥ 7 people per household); **Or**

☐ Child resides in a home with a lack of running water.

Note: The child in this category will qualify for monthly doses **only** up until 3 months (90 days) of age.

☐ Attachments

Attestation: I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Alaska Medicaid.

Prescriber Signature: _____ **Date:** _____

(required)

Prime Therapeutics Management LLC
Attn: GV – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

Phone: 800-331-4475

Fax this form to 888-603-7696

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