OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
Synagis® (Palivizumab) Initiation Prior Authorization Form

Member Name: _____ Sex: _____ ID #: _____

Date of birth: _____ Current Age: _____ (months) Gestational age (GA):_____ (weeks/days)

Prescriber Initials (*Required*) _____ (*confirming GA)* ☐ Dose received in hospital Date: _____

Birth Weight: _____kg Current Weight: _____ kg Date Recorded: _____

Drug Information

FDA approved dosing:15mg/kg intramuscularly. Only those doses that require greater than a vial's dose +10% may use the next vial size or an additional vial (e.g. 1-55mg = 50mg vial, 56-110mg = 100mg vial). Weight must be taken within the last 3 weeks. Each dose is to be given every 30 days.

Physician billing ☐CPT code 90378 (50mg/unit)

Pharmacy billing ☐50mg/0.5ml NDC:_____ ☐100mg/ml NDC:_____

Billing Provider Information

Provider _____ Provider NPI_____

Provider Phone: _____ Provider Fax: _____

Prescriber Information

Specialist:_____ Specialist NPI:_____

Specialist Phone:_____ Specialist Fax:_____

Primary Care Provider:_____ PCP address:_____

PCP NPI:_____ PCP Phone:_____ PCP Fax:_____

Product Selection Criteria

1. Has the member already received Beyfortus™ (nirsevimab-alip) for the current RSV season?
   Yes☐ No☐
   a. If yes, date received: _____
2. Please provide a patient-specific, clinically significant reason why the member cannot receive Beyfortus™ (nirsevimab-alip), as recommended by the CDC: _____

_____

_____

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114, Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*

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Member Name: _____ Date of Birth: _____ ID #: _____

Member Selection Criteria

Member must be included in **1** of the following age groups at the beginning of the RSV season:

- ☐ Infants younger than 12 months of age, born before 32 weeks, 0 days gestation and develop Chronic Lung Disease (CLD) of prematurity (require >21% oxygen supplementation for at least 28 days after birth).
- ☐ Infants and children 12 to 24 months of age, born before 32 weeks, 0 days gestation and develop CLD of prematurity (require >21% oxygen supplementation for at least 28 days after birth) who continue to require medical support (chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) during the 6 months before the start of the RSV season. Treatment/date received: _____

_____

- ☐ Infants younger than 12 months of age with moderate-to-severe pulmonary hypertension or with acyanotic heart disease on medications to control congestive heart failure and will require cardiac surgical procedures. Please list medications: _____

_____

- ☐ Infants younger than 12 months of age, born before 29 weeks, 0 days gestation.
- ☐ Infants younger than 12 months of age with neuromuscular disease or congenital anomaly that impairs the ability to clear secretions from the upper airway because of ineffective cough. Specify _____
- ☐ Infants and children younger than 24 months of age, who undergo cardiac transplantation during RSV season. Specify _____
- ☐ Infants younger than 12 months of age with cystic fibrosis with clinical evidence of CLD and/or nutritionally compromised. Specify _____
- ☐ Infants and children 12 to 24 months of age with cystic fibrosis with manifestations of severe lung disease or weight less than the 10th percentile. Specify _____
- ☐ Infants and children younger than 24 months of age, who are profoundly immunocompromised during RSV season. Specify _____

Additional information: _____

_____

_____

_____

Prescriber Signature (*Required*) _____ **Date** _____

Please do not send in chart notes. Specific information/documentation will be requested if necessary.

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