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Magellan Rx MANAGEMENT

NYRx the Medicaid Pharmacy Program

Synagis® (palivizumab) Prior Authorization Worksheet

Fax this form to 1-800-268-2990

Processing may be delayed if information submitted is illegible or incomplete.

ENROLLEE INFORMATION

Enrollee Last Name: _____

Enrollee First Name: _____

Enrollee Medicaid ID (2 letters, 5 numbers, 1 letter): _____

Date of Birth: _____ Current Weight: _____

Gestational Age: _____ Weeks _____ Days

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

National Provider Identifier (NPI) Number: _____

Board Certified Specialty: _____

Prescriber Street Address: _____

City: _____ State: _____ Zip Code: _____

Prescriber Phone: _____ Prescriber Fax: _____

REQUESTED DRUG INFORMATION

Drug Name: _____

Drug Strength: ☐ 50 mg/0.5 mL; Quantity: 1 vial

☐ 100 mg/1 mL; Quantity: ☐ 1 vial **Or** ☐ 2 vials

Total Monthly Dose: _____

Refills: _____ **Note**: 5-dose quantity limit

Directions: Inject 15 mg/kg IM once monthly

Is this a New Prescription?

☐ Yes ☐ No

If No, date therapy was initiated: _____

Enrollee's Name (Last, First): _____

CLINICAL CRITERIA

Section A: For Patients < 12 Months of Age at RSV Season Onset (October 16)

1. Has the patient received nirsevimab (Beyfortus™) related to the current RSV season?
   ☐ Yes ☐ No
2. Is patient < 12 months of age at the onset of the current RSV season (October 16)?
   ☐ Yes ☐ No

   If Yes, continue with questions 3–6 below (Section A). **If No**, please move to Section B.
3. Was the patient born at gestational age less than 29 weeks?
   ☐ Yes ☐ No
4. Does the patient:
   - Have Chronic Lung Disease (CLD) of prematurity (formerly called Bronchopulmonary Dysplasia); **And**
   - Gestational age less than 32 weeks; **And**
   - Require > 21% oxygen use for ≥ 28 days post-birth?

   ☐ Yes ☐ No
5. Does the patient have a congenital airway abnormality or neuromuscular disorder that decreases the ability to manage airway secretion?
   ☐ Yes ☐ No
6. Does the patient have hemodynamically significant heart disease (see examples below)?
   - Infant with acyanotic heart disease receiving medication to control congestive heart failure and will require cardiac surgery; **Or**
   - Infant with moderate to severe pulmonary hypertension; **Or**
   - Potentially, infant with cyanotic heart disease, with consultation by cardiologist.

   ☐ Yes ☐ No

Section B: For Patients < 24 Months of Age at RSV Season Onset (October 16)

7. Has the patient received nirsevimab (Beyfortus) related to the current RSV season?
   ☐ Yes ☐ No
8. Does the patient:
   - Have Chronic Lung Disease of prematurity; **And**
   - Require medical support (i.e., oxygen, bronchodilator, diuretic, chronic steroid therapy) within 6 months prior to second RSV season onset?

   ☐ Yes ☐ No
9. Does the patient require a solid-organ transplant during the current RSV season?
   ☐ Yes ☐ No

Enrollee's Name (Last, First): _____

CLINICAL CRITERIA (CONTINUED)

10. Is patient profoundly immunocompromised during RSV season?

☐ Yes ☐ No

If Yes, please provide additional information on cause of immunocompromised state:

11. Please provide any additional information that should be considered:

☐ Attachments

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

Attestation: I attest that Synagis® is medically necessary for this patient and that all the information on this form is accurate to the best of my knowledge. I attest that documentation of the above diagnosis and medical necessity is available for review if requested by New York Medicaid.

Fax Number: 1-800-268-2990

Prior Authorization Call Line: 1-877-309-9493

Billing Questions: 1-800-343-9000

For clinical questions or Clinical Drug Review Program questions, please visit http://newyork.fhsc.com or call 1-877-309-9493.