PRO ACT
PHARMACY BENEFIT MANAGEMENT

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Synagis® Prior Authorization Request Form (Page 1 of2)

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Prophylaxis of respiratory syncytial virus (RSV)

❑ Other diagnosis:_____ICD-10 Code(s): _____

Clinical Information:

Please document the patient's gestational age:_____weeks,_____days

Select the patient's age at the start of the RSV season:

- ❑ < 12 months
- ❑ 12 to < 24 months
- ❑ ≥ 24 months

Select if Synagis is prescribed by or in consultation with one of the following specialists:

- ❑ Infectious disease specialist
- ❑ Pediatric cardiologist
- ❑ Pediatric intensivist
- ❑ Pediatric pulmonologist
- ❑ Neonatologist
- ❑ Neurologist

Will Synagis be used for the prevention of serious lower respiratory tract infection caused by RSV during the RSV season for the patient's geographic region? ❑ **Yes** ❑ **No**

For chronic lung disease (CLD) of prematurity, also answer the following:

Did the patient receive greater than 21% oxygen supplementation for at least the first 28 days after birth? ❑ **Yes** ❑ **No**

For patients at least 12 to < 24 months at the start of the RSV season, did the patient receive medical support (i.e., chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) within 6 months before the start of the second RSV season? ❑ **Yes** ❑ **No**

For hemodynamically significant congenital heart disease, also answer the following:

For patients < 12 months of age at the start of RSV season, select if the patient has the following:

- ❑ Acyanotic heart failure
- ❑ Receiving medication to control congestive heart failure
- ❑ Patient will require a cardiac procedure
- ❑ Moderate to severe pulmonary hypertension
- ❑ Cyanotic heart defect

For patients < 24 months, has the patient undergone or will the patient be undergoing a cardiac transplantation during the RSV season? ❑ **Yes** ❑ **No**

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For pulmonary abnormality (e.g., pulmonary malformations, tracheoesophageal fistula, conditions requiring tracheostomy) or neuromuscular disorder (e.g., cerebral palsy), also answer the following: For patients < 12 months of age at the start of RSV season, does the patient have impaired ability to clear secretions from the upper airway due to an ineffective cough? ❑ **Yes** ❑ **No**
For immunocompromised children, also answer the following: Has the patient received or will receive a solid organ transplant, hematopoietic stem cell transplant, or chemotherapy during the RSV season? ❑ **Yes** ❑ **No** Is the patient's lymphocyte count below the normal range for the patient's age? ❑ **Yes** ❑ **No**
For children with cystic fibrosis, also answer the following: For patients < 12 months, is there clinical evidence of chronic lung disease and/or nutritional compromise (i.e., failure to thrive)? ❑ **Yes** ❑ **No** For patients at least 12 months to < 24 months, does the patient have severe lung disease (previous hospitalization for pulmonary exacerbation in the first year of life, abnormalities on chest radiography or chest computed tomography that persist when stable) or weight for length < 10th percentile on pediatric growth chart? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	