AmeriHealth Caritas Iowa
Request for Prior Authorization

Palivizumab (Synagis®)

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:	Patient name:	
Patient address:		DOB:
Provider NPI:	Prescriber name:	Phone:
Prescriber address:		Fax:
Pharmacy name:		
Address:		Phone:
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI:	Pharmacy fax:	NDC:

AmeriHealth Caritas Iowa follows the current American Academy of Pediatrics Guidelines for eligibility criteria for prophylaxis of high-risk infants and young children. Prior authorizations will be approved for administration during the RSV season for a maximum of 5 doses per patient. No allowances will be made for a sixth dose. Patients, who experience a breakthrough RSV hospitalization, should have their monthly prophylaxis discontinued, as there is an extremely low likelihood of a second RSV hospitalization in the same season.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

Preferred:

☐ **Synagis**

Strength: Dosage Instructions: Quantity: Days Supply:

Diagnosis: Gestational Age at Birth (week, day):

Patient meets at least one of the following criterion:

Chronic Lung Disease (CLD) of Prematurity:

- ☐ Patient is less than 12 months of age at start of therapy and has CLD of prematurity (defined as gestational age less than 32 weeks and required greater than 21% oxygen for at least the first 28 days after birth). (Please attach chart notes documenting oxygen use)
- ☐ Patient is 12 months to < 24 months meeting the CLD of prematurity definition above, and continues to require medical support during the 6-month period before the start of the second RSV season (defined as one or more of the following):
  - ☐ Chronic corticosteroid therapy
    Drug Name, Dose & Therapy Dates: ____________________
  - ☐ Diuretic therapy
    Drug Name, Dose and Therapy Dates: ____________________
  - ☐ Supplemental oxygen
    Therapy Dates: ____________________

Premature Infants (without CLD of Prematurity or CHD):

- ☐ Patient is less than 12 months of age at start of therapy with a gestational age less than 29 weeks.

Neuromuscular Disorders or Anatomic Pulmonary Abnormalities:

Patient is 12 months of age or younger at the start of therapy and has either severe neuromuscular disease or congenital anomaly that impairs the ability to clear secretions from the upper airway due to an ineffective cough.

Describe: ____________________

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Hemodynamically Significant Congenital Heart Disease (CHD):

Patient is less than 12 months of age at start of therapy and has hemodynamically significant congenital heart disease further defined by any of the following:

☐ Patient with acyanotic heart disease who is receiving medication to control congestive heart failure and will require cardiac surgical procedures.

- Hemodynamically Significant CHD diagnosis: ______________________
- Current Medication(s):
  Drug Name, Dose and Therapy Dates: ______________________
- Cardiac Surgical Procedure:
  Procedure & Expected Completion Date: ______________________

☐ Patient with moderate to severe pulmonary hypertension

☐ Requests for patients with cyanotic heart defects will be considered with documentation of consultation with a pediatric cardiologist that recommends patient receive palivizumab prophylaxis. (Provide consultation notes)

Immunodeficiency:

Patient is less than 24 months of age at start of therapy and is profoundly immunocompromised during the RSV season (e.g., severe combined immunodeficiency, advanced acquired immunodeficiency syndrome, receiving chemotherapy).

Describe: ______________________

Please indicate if the patient has received any previous Synagis® doses this RSV season.
If yes, please provide the date(s) of administration: ☐ No ☐ Yes Administration Date(s):______________________

Please indicate setting in which Synagis is to be administered:______________________

Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.	
Prescriber signature: (Must match prescriber listed above.)	Date of submission:

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.