Mountain Pacific
INNOVATING BETTER HEALTH
Mailing Address: P.O. Box 5119 | Helena, MT 59604
Phone: 406.443.6002 | Toll-free: 1.800.395.7961
Fax: 406.513.1928 | Toll-free: 1.800.294.1350

Montana Healthcare Programs Prior Authorization Request Form for Use of Synagis® (palivizumab)

Member's Name: _____ Member's ID #: _____ DOB: _____

Physician's Name: _____ Specialty: _____

Physician's Phone #: _____ Physician's Fax #: _____

Estimated gestational age (EGA) at time of birth: _____

Prior to this request, was Synagis® previously administered (hospital/NICU/other):

☐ No ☐ Yes Date(s): _____

Expected date of first/next dose (if previously administered): _____

Current weight of child at time of request: _____

Requirements: (Please check all that apply and submit any additional supporting documentation.)

1. Member age at onset of RSV season is **<12 months** (does not include first birthday) **AND** any of the following:

   ☐ **EGA <29 weeks**

   ☐ **EGA <32 weeks** with **a diagnosis of chronic lung disease (CLD) in the past 12 months** and history of requirement for **21% oxygen** for the **first 28 days after birth (CLD of prematurity)**

   Oxygen % used: _____ **Duration of use (start and stop dates):** _____

   ☐ Diagnosis of **hemodynamically significant acyanotic congenital heart disease in the past 12 months** AND history of **drugs to treat** congestive heart failure (CHF) or moderate to severe pulmonary hypertension in the **past 45 days.**

   Please list diagnosis, medications and dates taken:

   _____

   _____

   ☐ Diagnosis of **hemodynamically significant cyanotic congenital heart disease** in the past 12 months **AND prescriber is a pediatric cardiologist OR a pediatric cardiologist consult is attached.**

   ☐ Diagnosis of **severe neuromuscular disease or congenital respiratory abnormalities (does not include cystic fibrosis)** in the **past 12 months.**

   ☐ Member undergoing **cardiac transplantation** OR member is **profoundly immunocompromised** (e.g., stem cell or organ transplant, chemotherapy, etc.) **during respiratory syncytial virus (RSV) season**.

   Date of expected cardiac transplant: _____

   Explanation of immunocompromised status: _____

   _____

2. Member age at onset of RSV season is >**12 months** but **<24 months** (does not include second birthday) **AND** any of the following:

   ☐ Diagnosis of **CLD of prematurity in the past 2 years** WITH **history in past 6 months of O2 supplementation, diuretics or 3 or more claims for systemic or inhaled corticosteroids.**

   O2 supplementation start date: _____ stop date: _____

   Please list medications and dates taken: _____

   _____

   ☐ Member **undergoing cardiac transplantation** OR member is **profoundly immunocompromised during RSV season.**

   Date of expected cardiac transplant: _____

   Explanation of immunocompromised status: _____

   _____

Limitations:

1. The 2023-2024 season for Montana Medicaid RSV prophylaxis will begin September 1, 2023, and end April 30, 2024.
2. **Synagis® is only covered under the pharmacy benefit**. Synagis® must be billed by an enrolled Montana Healthcare Programs pharmacy and dispensed to a clinic/infusion center to be administered to the member. Synagis® is not covered under the medical benefit.
3. Approval will be for 1 dose per month up to a **maximum** of 5 doses during the RSV season.
4. Medicaid will allow one 50mg vial (0.5ml) OR one 100mg (1ml) vial. Doses above 100mg will require prior authorization based on member weight.

Please complete form, attach supporting documentation, and fax to:
Drug Prior Authorization Unit at 1-800-294-1350

12/2023