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DEPARTMENT OF HUMAN SERVICES

Prime THERAPEUTICS

Minnesota Health Care Programs
Synagis® Prior Authorization Form

Fax this form to 866-390-2778. A fax cover sheet is not required.

Use this form to request authorization for Synagis® only. If you would like to request other outpatient drugs dispensed at a pharmacy, please use the Prescription Drug Prior Authorization Form available at: Forms and Documents - Minnesota.

Submit the completed form with supporting documentation, such as relevant chart notes if necessary. Incomplete forms will be returned.

Date of Request: _____

REQUESTER INFORMATION

Requester Last Name: _____

Requester First Name: _____

Requester Phone: _____ Requester Affiliation: ☐ Pharmacy ☐ Prescriber

MEMBER INFORMATION

Member Last Name: _____

Member First Name: _____

Member ID: _____ Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Prescriber NPI: _____

Prescriber Phone: _____ Prescriber Fax: _____

DRUG INFORMATION

Drug Name: _____ Drug Strength: _____

Drug Dose: _____ Dosing Frequency: _____

Current Weight in kgs: _____ as of _____ Gestational Age: _____ weeks _____ days

ICD Diagnosis Code: _____ Requested Start Date: _____

Member's Full Name: _____

CLINICAL INFORMATION

1. Is the gestational age less than or equal to 28 weeks 6 days and the current age less than or equal to 12 months of age?

   ☐ Yes ☐ No

2. Is the infant or child less than or equal to 12 months of age at the time of request, with a diagnosis of one or more of the following that impacts pulmonary function: Interstitial Lung Disease (ILD), neuromuscular condition, or a congenital airway abnormality?

   ☐ Yes ☐ No

3. Is the gestational age less than 32 weeks and the current age less than 24 months of age with a diagnosis of Chronic Lung Disease (CLD) of prematurity or Bronchopulmonary Dysplasia (BPD) having required one of the following in the past 6 months:

   ☐ Supplemental O2

   ☐ Recent use of corticosteroid therapy

   ☐ Regular or intermittent use of diuretics

4. Is the infant or child less than 12 months of age at the time of request, with a diagnosis of hemodynamically significant heart disease or congenital heart disease, having one or more of the following:

   ☐ Currently receiving medication to control congestive heart failure

   ☐ Moderate to severe pulmonary hypertension

   ☐ Cyanotic heart disease

5. Is the infant or child less than 24 months of age who will be profoundly immunocompromised during the respiratory syncytial virus (RSV) season?

   ☐ Yes ☐ No

   a. If **YES**, please provide details:

6. Has a dose of Synagis® been administered in an inpatient setting?

   ☐ Yes ☐ No

   a. If **YES**, indicate the date the dose was administered: _____

   b. Provide additional medical justification:

   c. List medications (include medication name, start date and end date for diagnoses that require acceptable medical therapy):

Member's Full Name: _____

7. Does the patient have has a contraindication to the RSV immunization (nirsevimab-alip, Beyfortus [Sanofi])?

   ☐ Yes ☐ No

   a. If **YES**, please provide details:

8. Is the patient unable to receive the RSV immunization (nirsevimab-alip, Beyfortus [Sanofi])?

   ☐ Yes ☐ No

   a. If **YES**, please provide details:

☐ Attachments

Pharmacists may dispense up to a 72-hour supply of the prescribed medication. A 72-hour supply may be approved at point of sale when a level of service of 3 is entered on the claim. However, additional supplies will not be authorized if PA criteria are not met.

Mail requests to:

Prime Therapeutics Pharmacy LLC
Attn: GV – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

Phone: 844-575-7887

Fax this form to 866-390-2778