Prescription Drug Prior Authorization Request (Synagis)

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Sioux Falls, SD 57109
(855) 305-5062
Fax: (701) 234-4568
sanfordhealthplan.com

SANFORD HEALTH PLAN

Fax completed form and all supporting clinical information to Pharmacy Management Team at (701) 234-4568 or submit online at sanfordhealthplan.org/providerlogin.

This form is for: ☐ Formulary Exception ☐ Prior Authorization Request

Patient Information		Prescriber Information		
Patient Name:		Prescriber Name:		
Patient ID #:		Prescriber Specialty:		
DOB:		Address:		
Medication Allergies:		City:	State:	Zip:
Diagnosis		Phone:	Fax:	
Diagnosis:	ICD-10 :	Contact Person at Prescriber's Office:		

Medication Information				
Medication Being Requested:	Strength:	Directions:	Quantity	Days' Supply

Expected Length of Therapy:	Requested therapy medication is: ☐ new ☐ continuation of therapy If continuation of therapy, provide start date:

Medical Rationale for Use:

Patient's Gestational Age: _____Weeks _____Days

Current Weight _____kg _____ Date Recorded

****If approved Sanford Health plan will cover up to 5 doses, to be given between November 15 of the current year through April 15 of the following year****

CLINICAL CRITERIA	
Preterm Infants without Chronic Lung disease of Prematurity or Congenital Heart Disease	
Risk Factors?	☐ Young chronological age ≤ 12 weeks ☐ Pre-school or school aged siblings ☐ Daycare attendance outside the home ☐ Exposure to environmental air pollutants ☐ Severe neuromuscular disease ☐ Congenital abnormality of airway ☐ RSV activity per CDC National Respiratory and Enteric Virus Surveillance System ≥ 10%
Provide a letter of medical necessity from two (2) of the following three (3) subspecialties: Pediatric Infectious disease, Neonatology and Pediatric Pulmonology	Attach documentation

Preterm Infants with Chronic Lung disease of Prematurity	
Did the infant require >21% oxygen for at least the first 28 days after birth?	☐Yes ☐No
If yes, provide clinical documentation to support the use of >21% oxygen for at least the first 28 days after birth.	Attach documentation
In the past 6 months has the infant required any of the following: Chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen?	☐Yes ☐No
If yes, provide clinical documentation or pharmacy records support the use of one or more of the above.	Attach documentation
Infants with hemodynamically significant congenital heart disease (CHD)	
Indicate medication(s) infant is on to control congestive heart failure or pulmonary hypertension?	
Will the infant require cardiac surgical procedures?	☐Yes ☐No
Does the infant have moderate to severe pulmonary hypertension?	☐Yes ☐No
Has or will the infant undergo cardiac transplantation during the RSV season?	☐Yes ☐No
Provide a letter of medical necessity from a pediatric cardiologist.	Attach documentation
Children with Anatomic Pulmonary Abnormalities or Neuromuscular disease	
Provide clinical documentation that the infant has neuromuscular disease or congenital abnormality that impairs the ability to clear secretions from the upper airway.	Attach documentation
Immunocompromised Children	
Provide clinical documentation supporting the infant is profoundly immunocompromised.	Attach documentation
Children with Cystic Fibrosis	
In the past 6 months has the infant required any of the following: Chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen?	☐Yes ☐No
If yes, provide clinical documentation or pharmacy records support the use of one or more of the above.	Attach documentation
Has the infant been hospitalized in their first year of life for pulmonary exacerbation?	☐Yes ☐No
Does the infant have abnormalities on chest radiography or chest computed tomography that persist when stable?	☐Yes ☐No
Is the infant's weight less than the 10th percentile?	☐Yes ☐No

Deliver product to:	☐ MD Office ☐ Patient's home ☐ Clinic Clinic location: _____	Home health requested?	☐ Yes Agency name: _____ ☐ No

Prescriber Signature (same as prescriber listed above) Date of Submission

To provide required information, attach additional sheets, lab results and other supporting documentation as necessary.

Questions? Call the Pharmacy Management Department at (855) 305-5062 | TTY/TDD (877) 652-1844.

If you would like an interpreter, call Language Line Solutions at (800) 892-0675.