

**Synagis® (Palivizumab) Initiation Prior Authorization Form**

Member Name: \_\_\_\_\_ Sex: \_\_\_\_\_ ID #: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Current Age: \_\_\_\_\_ (months) Gestational age (GA): \_\_\_\_\_ (weeks/days)

**Prescriber Initials (Required)** \_\_\_\_\_ (confirming GA)  Dose received in hospital Date: \_\_\_\_\_

Birth Weight: \_\_\_\_\_ kg Current Weight: \_\_\_\_\_ kg Date Recorded: \_\_\_\_\_

**Drug Information**

FDA approved dosing: 15mg/kg intramuscularly. Only those doses that require greater than a vial's dose +10% may use the next vial size or an additional vial (e.g. 1-55mg = 50mg vial, 56-110mg = 100mg vial). Weight must be taken within the last 3 weeks. Each dose is to be given every 30 days.

Physician billing  CPT code 90378 (50mg/unit)

Pharmacy billing  50mg/0.5ml NDC: \_\_\_\_\_  100mg/ml NDC: \_\_\_\_\_

**Billing Provider Information**

Provider \_\_\_\_\_ Provider NPI \_\_\_\_\_

Provider Phone: \_\_\_\_\_ Provider Fax: \_\_\_\_\_

**Prescriber Information**

Specialist: \_\_\_\_\_ Specialist NPI: \_\_\_\_\_

Specialist Phone: \_\_\_\_\_ Specialist Fax: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_ PCP address: \_\_\_\_\_

PCP NPI: \_\_\_\_\_ PCP Phone: \_\_\_\_\_ PCP Fax: \_\_\_\_\_

**Product Selection Criteria**

1. Has the member already received Beyfortus™ (nirsevimab-alip) for the current RSV season?

Yes \_\_\_ No \_\_\_

a. If yes, date received: \_\_\_\_\_

2. Please provide a patient-specific, clinically significant reason why the member cannot receive Beyfortus™ (nirsevimab-alip), as recommended by the CDC: \_\_\_\_\_

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy  
Pharmacy Management Consultants  
Product Based Prior Authorization Unit  
Fax: 1-800-224-4014  
Phone: 1-800-522-0114, Option 4

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State of Oklahoma  
SoonerCare

Synagis® (Palivizumab) Initiation Prior Authorization Form

Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ ID #: \_\_\_\_\_

Member Selection Criteria

Member must be included in 1 of the following age groups at the beginning of the RSV season:

- Infants younger than 12 months of age, born before 32 weeks, 0 days gestation and develop Chronic Lung Disease (CLD) of prematurity (require >21% oxygen supplementation for at least 28 days after birth).
- Infants and children 12 to 24 months of age, born before 32 weeks, 0 days gestation and develop CLD of prematurity (require >21% oxygen supplementation for at least 28 days after birth) who continue to require medical support (chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) during the 6 months before the start of the RSV season. Treatment/date received: \_\_\_\_\_
- Infants younger than 12 months of age with moderate-to-severe pulmonary hypertension or with acyanotic heart disease on medications to control congestive heart failure and will require cardiac surgical procedures. Please list medications: \_\_\_\_\_
- Infants younger than 12 months of age, born before 29 weeks, 0 days gestation.
- Infants younger than 12 months of age with neuromuscular disease or congenital anomaly that impairs the ability to clear secretions from the upper airway because of ineffective cough. Specify \_\_\_\_\_
- Infants and children younger than 24 months of age, who undergo cardiac transplantation during RSV season. Specify \_\_\_\_\_
- Infants younger than 12 months of age with cystic fibrosis with clinical evidence of CLD and/or nutritionally compromised. Specify \_\_\_\_\_
- Infants and children 12 to 24 months of age with cystic fibrosis with manifestations of severe lung disease or weight less than the 10th percentile. Specify \_\_\_\_\_
- Infants and children younger than 24 months of age, who are profoundly immunocompromised during RSV season. Specify \_\_\_\_\_

Additional information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Prescriber Signature (Required) \_\_\_\_\_ Date \_\_\_\_\_

Please do not send in chart notes. Specific information/documentation will be requested if necessary.

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