Prescription Drug Prior Authorization Request (Synagis)

FAX TO (701) 234-4568

PO Box 91110
Sioux Falls, SD 57109-1110
Toll-Free: (855) 305-5062
TTY/TDD: (877) 652-1844
Fax: (701) 234-4568

SANFORD HEALTH PLAN

INSTRUCTIONS:

1. All fields must be completed and legible for review.
2. **The Plan's decision will be based on individual plan policy and clinical documentation submitted.**
3. Fax completed form to the number above, or submit online through your provider portal at sanfordhealthplan.com/providerlogin. Prior authorizations *cannot* be completed over the phone.
4. **If approved, Sanford Health Plan will cover up to 5 doses, to be given between November 15th of the current year through April 15th of the following year.**
5. Questions? Contact Pharmacy Management Department at (855) 305-5062.

Please check the appropriate box below. This form is being used for:

☐ Formulary Exception ☐ Prior Authorization (PA) Request ☐ Unsure/Unknown

Member Information

Member Name:	Member's Gestational Age:
Date of Birth:	_____ Weeks _____ Days
Member ID #:	Member's Current Weight:
Drug Allergies:	_____ kg _____ Date Recorded

Diagnosis

PRIMARY DIAGNOSIS (ICD-10 CODE):	SECONDARY DIAGNOSIS (ICD-10 CODE):
DESCRIPTION:	DESCRIPTION:

Prescription Drug Information

Medication being requested:	Strength:	Quantity:	Day's Supply:
HCPC (if applicable):	Directions for use:		

Requested therapy medication is: ☐ New ☐ Continuation of therapy ** If continuation, provide start date:	Medical rationale for use:
Expected length of therapy:	
☐ Check here if this request is for retroactive coverage for a previous claim or date of service. Date of service: _____	

Provider Information

Prescriber name (first & last):	☐ MD ☐ NP ☐ DO ☐ APRN ☐ PA ☐ _____
Specialty:	NPI #:
Address:	
City, State, Zip:	
Phone:	Fax:
Contact person at provider's office:	

How will medication be obtained?

☐	**Buy and Bill**	Tax ID:
	Facility Name:	
	Address:	
	City, State, Zip:	

☐	**Pharmacy**	Tax ID:
	Pharmacy Name:	

Is home health requested?

☐ Yes ☐ No	Agency Name:

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Clinical Information Submitted for Determination

To provide required information, attach additional sheets, lab results, and other supporting documentation as necessary. Denote which pages of the records to review to help expedite the review process.

Preterm Infants without Chronic Lung Disease of Prematurity or Congenital Heart Disease		
Risk factors?	☐ Young chronological age ≤ 12 weeks ☐ Severe neuromuscular disease ☐ Congenital abnormality of the airway ☐ Exposure to environmental air pollutants	☐ Preschool or school aged siblings ☐ Daycare attendance outside the home ☐ 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: 1. Pediatric Infectious Disease 2. Neonatology 3. 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 to support the use of one or more of the above.	Attach Documentation

Infants with hemodynamically significant congenital heart disease (CHD)	
List 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 that 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 to 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

Prescriber signature (same as prescriber listed above): _____ Date Submitted: _____

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