



**HUSKY Health Program
Palivizumab (Synagis®) Prior Authorization Request Form
Phone: 1.800.440.5071**

**2023-2024
RSV Season**

**THIS FORM IS TO BE COMPLETED BY THE ORDERING PROVIDER
AND FAXED TO ONE OF THE PHARMACIES LISTED BELOW.**

<input type="checkbox"/> CVS/Caremark® Phone: 1.800.237.2767 Fax: 1.800.323.2445	<input type="checkbox"/> Walgreens Phone: 1.866.230.8102 Fax: 1.888.325.6544
Patient Name:	Parent/Guardian Name:
Medicaid ID#:	Address:
DOB:	City/State/Zip:
Birth Weight: lbs. oz. OR kg.	Phone:
Current Weight: lbs. oz. OR kg.	Date Weight Recorded:
Previous Dose Given: <input type="checkbox"/> Yes <input type="checkbox"/> No Date:	Expected Date of First Injection:
First dose given in practitioner's office; subsequent doses to be administered: <input type="checkbox"/> In Office/Clinic <input type="checkbox"/> In Patient's Home	
Has the infant received BEYFORTUS™ (nirsevimab-alip) during this RSV season? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Authorization expires 4/30/2024 unless otherwise indicated; HUSKY Health program to coordinate home administration.	
Gestational Age and ICD-10-CM Code:	
<input type="checkbox"/> < 23 weeks (P07.21) <input type="checkbox"/> 23 weeks (P07.22) <input type="checkbox"/> 24 weeks (P07.23) <input type="checkbox"/> 25 weeks (P07.24) <input type="checkbox"/> 26 weeks (P07.25) <input type="checkbox"/> 27 weeks (P07.26) <input type="checkbox"/> 28 weeks (P07.31) <input type="checkbox"/> 29 weeks (P07.32) <input type="checkbox"/> 30 weeks (P07.33) <input type="checkbox"/> 31 weeks (P07.34) <input type="checkbox"/> 32 weeks (P07.35) <input type="checkbox"/> 33 weeks (P07.36) <input type="checkbox"/> 34 weeks (P07.37) <input type="checkbox"/> 35 weeks (P07.38) <input type="checkbox"/> 36 weeks (P07.39)	
Criteria — Check only <u>one</u> category and enter the diagnosis/ICD-10-CM code that is <u>most applicable</u> to the clinical situation:	
<input type="checkbox"/> 1. Infant born before 29 weeks, 0 days gestational age, and who is up to 12 months of age as of 11/01/2023 (five doses max) • ICD-10-CM code identifying patient's gestational age: _____	
<input type="checkbox"/> 2. Preterm infant born before 32 weeks, 0 days gestational age, with chronic lung disease of prematurity defined as a requirement for greater than 21% oxygen for at least 28 days after birth, AND who is up to 12 months of age as of 11/01/2023 (five doses max) • ICD-10-CM code identifying patient's gestational age: _____ • ICD-10-CM code that best describes the patient's lung disease of prematurity: _____ (Requires documentation of oxygen needs after birth)	
<input type="checkbox"/> 3. Infant with hemodynamically significant heart disease, and who is up to 12 months of age as of 11/01/2023 (five doses max) Diagnosis: _____ ICD-10-CM Code: _____ (Requires documentation of indicated diagnosis)	
<input type="checkbox"/> 4. Child between 12 and 24 months of age as of 11/01/2023, born before 32 weeks, 0 days gestation, who required at least 28 days of supplemental oxygen after birth, and who continued to require medical intervention (supplemental oxygen, systemic corticosteroids, or diuretic therapy) during the six months prior to the start of the second RSV season (five doses max) Diagnosis: _____ ICD-10-CM Code: _____ (Requires documentation of oxygen needs after birth and current medical intervention(s))	
<input type="checkbox"/> 5. Other: Child who will be profoundly immunocompromised during the RSV season, and who is up to 24 months of age as of 11/01/2023 (five doses max) Diagnosis: _____ ICD-10-CM Code: _____ (Requires documentation of immunocompromised state)	
<input type="checkbox"/> 6. Other: Child with pulmonary abnormality or neuromuscular disease that impairs the ability to clear secretions from the upper airways, and who is up to 12 months of age as of 11/01/2023 (five doses max) Diagnosis: _____ ICD-10-CM Code: _____ (Requires documentation of indicated diagnosis)	

PHARMACIES SHOULD FAX COMPLETED REQUESTS TO THE HUSKY HEALTH PROGRAM AT 203.774.0549.



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Prescription		
Synagis® (palivizumab) <input type="checkbox"/> Syringes _____ <input type="checkbox"/> Other _____		
Sig <input type="checkbox"/> Inject 15mg./kg. <u>one time per month</u> Refills* 1 2 3 4 (choose one, based on AAP recommendations)		
Practitioner Signature:		Date:
Practitioner Name:		Office Contact:
Hospital/Practice:		Phone:
Address:	Fax:	NPI #:
City/State/Zip:	License #:	DEA #:

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