

# ANTIVIRAL MONOCLONAL ANTIBODIES PRIOR AUTHORIZATION REQUEST FORM



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Today's Date

/ 
   /

**Note:** This form must be completed by the prescribing provider.

**\*\*All sections must be completed or the request will be returned\*\***

Patient's Medicaid # <input style="width: 100%;" type="text"/>	Date of Birth <input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/>
Patient's Name <input style="width: 100%;" type="text"/>	Prescriber's Name <input style="width: 100%;" type="text"/>
Prescriber's IN License # <input style="width: 100%;" type="text"/>	Specialty <input style="width: 100%;" type="text"/>
Prescriber's NPI # <input style="width: 100%;" type="text"/>	Prescriber's Signature <input style="width: 100%;" type="text"/>
Return Fax # <input style="width: 15%;" type="text"/> - <input style="width: 15%;" type="text"/> - <input style="width: 15%;" type="text"/> <input style="width: 15%;" type="text"/> <input style="width: 15%;" type="text"/> <input style="width: 15%;" type="text"/>	Return Phone # <input style="width: 15%;" type="text"/> - <input style="width: 15%;" type="text"/> - <input style="width: 15%;" type="text"/> <input style="width: 15%;" type="text"/> <input style="width: 15%;" type="text"/> <input style="width: 15%;" type="text"/>
Check box if requesting retro-active PA <input type="checkbox"/>	Date(s) of service requested for retro-active eligibility (if applicable): <input style="width: 100%;" type="text"/>

*Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).*

### PA Requirements for Synagis (palivizumab):

1. Patient Information:
 

Actual Gestational Age: \_\_\_\_\_ weeks \_\_\_\_\_ days

Current Age (Must be < 24 months): \_\_\_\_\_ months

Current Weight: \_\_\_\_\_  kg  lb
2. Prescription Information:  Inject 15mg/kg IM once per month through March 31st  
 Other: \_\_\_\_\_
3. Palivizumab Prior Authorization Criteria Guidelines for a maximum of 5 doses (approval will be granted under any of the following circumstances)^:
 

**If member is less than 12 months of age, select one of the following that is applicable:**

Member was born before 29 weeks, 0 days' gestation

Member was born before 32 weeks, 0 days' gestation and has CLD necessitating more than 21% oxygen for at least the first 28 days of life

Please provide dates of oxygen supplementation/medication intervention:

\_\_\_\_\_

- Member has hemodynamically significant heart disease (e.g., acyanotic heart disease receiving medication to control CHF and will require cardiac surgical procedures, or those with moderate to severe pulmonary hypertension)

Please provide relevant diagnoses/medical intervention:

\_\_\_\_\_

- Member has congenital airway abnormality or neuromuscular disease that impairs the ability to clear secretions

Please provide relevant diagnoses/medication intervention:

\_\_\_\_\_

- Member has cystic fibrosis with clinical evidence of CLD and/or nutritional compromise

**If member is less than 24 months of age, select one of the following that is applicable:**

- Member is or will be considered to be profoundly immunocompromised (must provide chart documentation and explicitly state how member is or will be considered to be profoundly immunocompromised during the RSV season), including members undergoing cardiac transplantation during current RSV season

Please explain:

\_\_\_\_\_

- Member was born before 32 weeks, 0 days' gestation and required at least 28 days of supplemental oxygen after birth and who continued to require supplemental oxygen, chronic systemic corticosteroid therapy, diuretic, or bronchodilator therapy within 6 months of the start of the second RSV season

Please provide dates of oxygen supplementation/medication intervention:

\_\_\_\_\_

- Member has cystic fibrosis with manifestations of severe lung disease (previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest imaging that persist when stable) or weight-for-length <10<sup>th</sup> percentile

Please provide relevant diagnoses/medical intervention:

\_\_\_\_\_

4. Prescriber has submitted valid medical justification for the use of Synagis (palivizumab) over Beyfortus (nirsevimab)\*\*  YES  NO

Medical justification: \_\_\_\_\_

\_\_\_\_\_

**\*\* For the 2023-2024 RSV season, lack of Beyfortus availability will be considered a medically justifiable reason for use of Synagis (palivizumab)**

5. Prescriber attests member has NOT received Beyfortus (nirsevimab) within the same RSV season

Prescriber signature: \_\_\_\_\_

**Note:** Prophylaxis will be given only until the infant or child reaches a maximum of 5 doses or the end of the RSV season, whichever comes first

**^The Respiratory Syncytial Virus (RSV) season is defined as November 1<sup>st</sup> through March 31<sup>st</sup>. The Office of Medicaid Policy & Planning may extend the season based on statewide virology data. Requests for additional doses beyond the initial 5 approved doses will require separate prior authorization.**

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