

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS FAMILY HEALTH PLAN (MEDICAID)  
Synagis (IL88)

This fax machine is located in a secure location as required by HIPAA regulations.  
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois Medicaid at **1-844-242-0908**.  
Please contact Aetna Better Health Illinois Medicaid at **1-866-212-2851** with questions regarding the Prior Authorization process.

When conditions are met, we will authorize the coverage of Synagis (IL88).  
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

Synagis (palivizumab)

Quantity \_\_\_\_\_ Frequency \_\_\_\_\_ Strength \_\_\_\_\_  
Route of Administration \_\_\_\_\_ Expected Length of therapy \_\_\_\_\_

Patient Information

Patient Name: \_\_\_\_\_  
Patient ID: \_\_\_\_\_  
Patient Group No.: \_\_\_\_\_  
Patient DOB: \_\_\_\_\_  
Patient Phone: \_\_\_\_\_

Prescribing Physician

Physician Name: \_\_\_\_\_  
Specialty: \_\_\_\_\_ NPI Number: \_\_\_\_\_  
Physician Fax: \_\_\_\_\_ Physician Phone: \_\_\_\_\_  
Physician Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_

Please circle the appropriate answer for each question.

1. Is Synagis requested for the prevention of respiratory syncytial virus (RSV) infections in a child who is at high risk of RSV disease? Y N

[If no, then no further questions.]

2. Is the patient 2 years of age or younger at the start of the RSV season? Y N

[If no, then no further questions.]

- |  |   |   |
|--|---|---|
| 3. Is Synagis requested for a preterm infant who was delivered at less than 32 weeks gestation with a diagnosis of chronic lung disease (CLD) who has required medical therapy with supplemental oxygen, bronchodilator, diuretic or chronic corticosteroid therapy for CLD within 6 months prior to RSV season? | Y | N |
| [If yes, skip to question 15.]   |   |   |
| 4. Is Synagis requested for a preterm infant who was delivered at less than 29 weeks gestation and was 12 months of age or younger at the start of RSV season?   | Y | N |
| [If yes, skip to question 15.]   |   |   |
| 5. Is Synagis requested for a child who is profoundly immunocompromised during RSV season?   | Y | N |
| [If yes, skip to question 15.]   |   |   |
| 6. Is Synagis requested for a child with hemodynamically significant congenital heart disease?   | Y | N |
| [If no, then skip to question 13.]   |   |   |
| 7. Has the child undergone a cardiac transplant during the RSV season?   | Y | N |
| [If yes, skip to question 15.]   |   |   |
| 8. Was the child 12 months of age or younger at the start of the RSV season?   | Y | N |
| [If no, then no further questions.]  |   |   |
| 9. Does the child have a diagnosis of moderate to severe pulmonary hypertension?   | Y | N |
| [If yes, skip to question 15.]   |   |   |
| 10. Was Synagis recommended by a pediatric cardiologist for a child with cyanotic heart disease?   | Y | N |
| [If yes, skip to question 15.]   |   |   |
| 11. Was Synagis recommended by a pediatric cardiologist for a child with acyanotic heart disease?  | Y | N |
| [If no, then no further questions]   |   |   |

12. Does the patient meet all of the following? A) Currently receiving medication to control congestive heart failure, and B) Will require cardiac surgical procedure

Y N

[If yes, skip to question 15.]

[If no, then no further questions.]

13. Is Synagis requested for a child 12 months of age or younger with a diagnosis of neuromuscular disease or a congenital anomaly that impairs the ability to clear secretions from the upper airway?

Y N

[If yes, skip to question 15.]

14. Does the patient meet all of the following? A) 12 months of age or younger at the start of the RSV season, B) Preterm infant who was delivered at less than 32 weeks gestation, C) Diagnosis of chronic lung disease (CLD), and D) Required more than 21% oxygen for at least 28 days after birth

Y N

[If no, then no further questions.]

15. Will Synagis be given in a dose of 15mg per kilogram?

Y N

Please provide: Current weight: \_\_\_\_\_  
g/kg/lbs Date: \_\_\_\_\_

Comments:

---

---

I affirm that the information given on this form is true and accurate as of this date.

---

Prescriber (Or Authorized) Signature Date