Kansas Medical Assistance Program	**Aetna Better Health of KS**	**Sunflower**	**UnitedHealthcare**
PA Phone 800-933-6593	PA Pharmacy Phone 855-221-5656	PA Pharmacy Phone 877-397-9526	PA Pharmacy Phone 800-310-6826
PA Fax 800-913-2229	PA Pharmacy Fax 844-807-8453	PA Pharmacy Fax 833-645-2740	PA Pharmacy Fax 866-940-7328
	PA Medical Phone 855-221-5656	PA Medical Phone 877-644-4623	PA Medical Phone 866-604-3267
	PA Medical Fax 855-225-4102	PA Medical Fax 888-453-4756	PA Medical Fax 866-943-6474

Synagis® (palivizumab)
Prior Authorization Request Form

Beneficiary Information

Name: ______________________________

Medicaid ID #: ____________________ Date of Birth: ____________________

Billing Provider Information (Pharmacy, Physician, or Facility)

Name: ____________________ Medicaid ID #: ____________________

NPI #: ____________ Phone #: ____________ Fax #: ____________

Requested Drug: ____________________ NDC: ____________________

Procedure Code: ____________________ #Units Ordered: ____________________

Prescriber Information

Name: ____________________ Medicaid ID #: ____________________

NPI #: ____________ Phone #: ____________ Fax #: ____________

Requested information for the First RSV Season

Child's gestational age at birth: ____________

Check if the child has any of the following (check all the apply):

- □ Cystic Fibrosis
- □ Chronic Lung Disease of Prematurity
- □ Moderate to severe pulmonary hypertension
- □ Acyanotic CHD receiving medication to control CHF
- □ Other diagnosis: ____________________
- □ Profoundly immunocompromised during the RSV season
- □ Undergoing cardiac transplant during RSV season
- □ Nutritional compromise
- □ Neuromuscular condition that compromises handling of respiratory secretions

Did child require oxygen at birth? □ Yes □ No Days on O2 after birth: ________ % of O_2: ________

Requested Information for Second RSV Season

Child's gestational age at birth: ____________ Weight for length percentile: ____________

Did child require oxygen at birth? □ Yes □ No Days on O2 after birth: ________ % of O_2: ________

Check if the child has any of the following (check all the apply):

- □ Cystic Fibrosis
- □ Undergoing cardiac transplant during RSV season
- □ Profoundly immunocompromised during the RSV season
- □ Chronic Lung Disease

Did the child require any of the following within the past 6 months? (check all that apply)

□ Supplemental O_2 □ Chronic Systemic Corticosteroid Therapy □ Bronchodilator Therapy

During the first year of life, did the child have severe lung disease (example: previous hospitalization for pulmonary exacerbation or abnormalities on chest X-Ray or chest CT that persists when stable? □ Yes □ No

Requested Information for Additional Off-Season Doses

KS PCR % positivity per CDC: https://www.cdc.gov/surveillance/nrevss/images/rsvstate/RSV4PPCent3AVG_StateKS.htm

Date of most recent reporting week ____/____/____ % positive ________%

Date of previous reporting week ____/____/____ % positive ________%

Prescriber's Signature: ______________________________ **Date:** ____________

Complete form in its entirety and fax to the appropriate plan's PA department.
For questions, please call the pharmacy helpdesk specific to the member's plan.

 Revised November 2021