

**Alabama Medicaid Agency**  
**Synagis® Prior Authorization Criteria**

1. Is the infant's gestational age  $\leq$  28 wks, 6 days and chronological age<sup>1</sup> less than 12 months old?  
 Yes (If yes, go to # 7)  
 No (If no, go to # 2)
2. Is the infant's gestational age 29 wks up to 31 wks, 6 days and chronological age<sup>1</sup> less than 6 months old?  
 Yes (If yes, go to # 7)  
 No (If no, go to # 3)
3. Is the infant's gestational age 32 wks, 0 days-34 wks, 6 days & infant is < 3 months old at start of RSV season OR born during the RSV season<sup>3</sup>? At least one of the two AAP risk factors must be applicable (childcare attendance, sibling younger than 5 yrs of age [multiple birth siblings younger than 1 year of age do not qualify for this risk factor]).  
 Yes (If yes, go to # 7)  
 No (If no, go to # 4)
4. Is the infant's chronological age<sup>1</sup>  $\leq$  12 months with a diagnosis<sup>2</sup> of congenital abnormalities of the airway or neuromuscular disease that compromises handling of respiratory secretions? Supporting documentation\* of diagnosis/ICD-9 code must be included.  
 Yes (If yes, go to #7)  
 No (If no, go to # 5)
5. Is the patient less than 24 months of age with a diagnosis of Chronic Lung Disease<sup>2</sup> (CLD) of prematurity (defined as gestational age less than 35 weeks) and has received medical therapy (supplemental oxygen [ $>21\%$  for at least 28 days, vent not required], bronchodilator, diuretic, or chronic corticosteroid therapy) within 6 months before the start of the RSV season or who continue to require medical therapy (as defined above). Supporting documentation\* of diagnosis/ICD9 code and medical therapy must be included.  
 Yes (If yes, indicate treatment below and go to #7)  
 No (If no, go to #6)
6. Is the patient 24 months of age or younger with a diagnosis of hemodynamically significant cyanotic or acyanotic Congenital Heart Disease(CHD) with one of the following:  
(a) Congenital heart disease patient who is receiving medication<sup>2</sup> to control congestive heart failure (CHF), or  
(b) moderate to severe pulmonary hypertension<sup>2</sup>, or  
(c) cyanotic heart disease with no or incomplete surgical correction of defect<sup>2</sup>?  
Supporting documentation\* of diagnosis/ICD9 code as well as medications (if applicable) must be included.  
 Yes (If yes for 6a, 6b or 6c, go to #7)  
 No (If no, deny)
7. Is the patient currently an outpatient and has not been enrolled as an inpatient within 2-weeks of the date the Synagis® is requested? Enter discharge date (if applicable) \_\_\_\_\_  
 Yes (If yes, approve request)  
 No (If no, deny)

**(NOTE:** If discharge date does not reflect a 2 week period, approval may be given to be effective 2 weeks post hospital discharge)

**One of the first 6 criteria and the final criterion must be met before approval can be granted. A copy of the hospital discharge summary from birth or documentation of the first office visit with pertinent information (gestational age, diagnosis, etc.) is required on all Synagis PA requests. RSV prophylaxis approval will terminate March 31. RSV season is defined by the Alabama Medicaid Agency as October 1 through March 31.**

**NOTE: Approval authorizes only one dose (based on patient weight) every twenty-eight days up to a five (5) dose maximum or through March 31. A dose is defined as the calculated dosage [patient weight (kg) X 15mg/kg + 100 mg/ml of Synagis®]. The results of the calculation will be the number of mls the patient needs. Use the appropriate combination of vials to get the correct dose. No dose may be given after March 31. Requests for more than one dose in a 28 day period cannot be approved. If the patient received a dose in an inpatient setting, approval will only be given for 4 doses, with the exception of infants identified in item number 3. Retroactive requests must be submitted and billed within 6 months of the dispense date. Letters will be faxed to both prescriber and dispensing pharmacy notating approval or denial. If approved, each monthly subsequent dose will require submission of the recipient's current weight and last injection date, and may be faxed to HID utilizing the PA approval letter by the prescribing physician or dispensing pharmacy.**

**\*Supporting documentation is supplemental information submitted to support the patient meeting the criteria. Supporting documentation may include copies of hospital discharge notes, progress notes, pharmacy profiles, etc., and must include all medications, frequency of medication dosing, and diagnosis(es) with indications of severity of illness. A periodic review of medical records will be conducted by the Alabama Medicaid Agency or designees. Stamps/copies of physician's signatures will not be accepted.**

<sup>1</sup>Chronological age at the start of the RSV Season

<sup>2</sup>Please refer to Appendix A of the Synagis® Prior Authorization Instruction Worksheet for acceptable diagnosis/ICD-9 codes for all applicable diagnoses as well as acceptable medications used in CHD.

<sup>3</sup>A maximum of three doses will be approved for this group. Administration of Synagis is not recommended for children greater than 3 months of age in this patient population.