



Texas Standard Prior Authorization Form Addendum

**Molina Healthcare of Texas
Synagis (Medicaid)**

This fax machine is located in a secure location as required by HIPAA Regulations. Complete / Review information, sign, and date. Fax signed forms to Molina Pharmacy Prior Authorization Department at **1-888-487-9251**. Please contact Molina Pharmacy Prior Authorization Department at **1-855-322-4080** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Synagis (Medicaid).

Drug Name (select from list of drugs shown)	
Synagis (palivizumab) 100mg/1mL	Synagis (palivizumab) 50mg/0.5mL

Patient Information			
Patient Name:			
Patient ID:		County of Residence:	
Patient Date of Birth:			
Patient Weight:			

Prescribing Physician	
Physician Name:	
Physician Phone:	
Physician Fax:	
Physician Address:	
City, State, Zip:	

Diagnosis:	ICD Code:
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Please circle the appropriate answer for each question.

1. Is Synagis being prescribed for the prevention of serious lower respiratory tract disease caused by RSV in a child at high risk of RSV disease? Y N

*If the answer to this question is yes, go to question 2.
If the answer to this question is no, denied.*
2. Is the patient's chronological age less than 24 months at the start of the RSV season? Y N

*If the answer to this question is yes, go to question 3.
If the answer to this question is no, denied.*
3. Does the patient have an active diagnosis of chronic lung disease (CLD) of prematurity defined as birth at gestational age less than (<) 32 weeks, 0 day WITH greater than (>) 21% oxygen for at least 28 days after birth? Y N

*If the answer to this question is yes, go to question 4.
If the answer to this question is no, go to question 6.*
4. Is the patient's chronological age less than 12 months at the start of the RSV season? Y N

*If the answer to this question is yes, go to question 19.
If the answer to this question is no, go to question 5.*

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|-----|---|---|---|
| 5. | <p>Within the 6 months prior to the current RSV season, has the patient required ANY of the following therapies?</p> <ul style="list-style-type: none"> • Chronic use of corticosteroids • Diuretics • 21% Supplemental oxygen • Long-term mechanical ventilator • Bronchodilator therapy <p><i>If the answer to this question is yes, go to question 19.</i>
 <i>If the answer to this question is no, denied.</i></p> | Y | N |
| 6. | <p>Does the patient have a diagnosis of cystic fibrosis?</p> <p><i>If the answer to this question is yes, go to question 7.</i>
 <i>If the answer to this question is no, go to question 10.</i></p> | Y | N |
| 7. | <p>Is the patient's chronological age less than 12 months at the start of the RSV season?</p> <p><i>If the answer to this question is yes, go to question 9.</i>
 <i>If the answer to this question is no, go to question 8.</i></p> | Y | N |
| 8. | <p>Does the patient meet either of these conditions?</p> <ul style="list-style-type: none"> • Diagnosis of severe lung disease (previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest radiography or chest computed tomography that persist when stable) • Weight less than the 10th percentile <p><i>If the answer to this question is yes, go to question 19.</i>
 <i>If the answer to this question is no, denied.</i></p> | Y | N |
| 9. | <p>Does the patient meet either of these conditions?</p> <ul style="list-style-type: none"> • Clinical evidence of chronic lung disease • Nutritional compromise <p><i>If the answer to this question is yes, go to question 19.</i>
 <i>If the answer to this question is no, denied.</i></p> | Y | N |
| 10. | <p>Was the patient born at gestational age less than or equal to () 28 6/7 weeks?</p> <p><i>If the answer to this question is yes, go to question 18.</i>
 <i>If the answer to this question is no, go to question 11.</i></p> | Y | N |
| 11. | <p>Does the patient have severe congenital abnormality of airway or severe neuromuscular disease that impairs the ability to clear secretions from the upper airway due to ineffective cough?</p> <p><i>If the answer to this question is yes, go to question 18.</i>
 <i>If the answer to this question is no, go to question 12.</i></p> | Y | N |
| 12. | <p>Does the patient have an active diagnosis of hemodynamically significant heart disease?</p> <p><i>If the answer to this question is yes, go to question 13.</i>
 <i>If the answer to this question is no, go to question 17.</i></p> | Y | N |
| 13. | <p>Does the patient have moderate to severe pulmonary hypertension?</p> <p><i>If the answer to this question is yes, go to question 18.</i>
 <i>If the answer to this question is no, go to question 14.</i></p> | Y | N |
| 14. | <p>Does the patient have unrepaired cyanotic congenital heart disease?</p> <p><i>If the answer to this question is yes, go to question 15.</i>
 <i>If the answer to this question is no, go to question 16.</i></p> | Y | N |
| 15. | <p>Is Synagis being prescribed by or in consultation with a pediatric cardiologist?</p> <p><i>If the answer to this question is yes, go to question 18.</i>
 <i>If the answer to this question is no, denied.</i></p> | Y | N |

16. Does the patient have congenital heart failure (CHF) requiring medication? Y N
If the answer to this question is yes, go to question 18.
If the answer to this question is no, denied.
17. Does the patient have ANY of the following conditions, which leaves the patient Y N
 profoundly immunocompromised?
 • solid organ transplant
 • hematopoietic stem cell transplant
 • chemotherapy
 • other condition that leaves the infant profoundly immunocompromised, which is NOT one of
 the following:
 o Congenital heart disease adequately-corrected by surgery not requiring medication,
 o Mild cardiomyopathy not requiring medical therapy
 o Secundum atrial septal defect
 o Small ventriculoseptal defect
 o Pulmonic stenosis
 o Uncomplicated aortic stenosis
 o Mild coarctation of the aorta
 o Patent ductus arteriosus
 o Any other hemodynamically insignificant heart disease
 o Tobacco smoke exposure
If the answer to this question is yes, go to question 19.
If the answer to this question is no, denied.
18. Is the patient less than 12 months of age at the start of RSV season? Y N
If the answer to this question is yes, go to question 19
If the answer to this question is no, denied.
19. Has the client been hospitalized for RSV since the start of the current RSV season? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 20.
20. Has the patient received 5 doses of Synagis since the beginning of the current RSV season until Y N
 today?
If the answer to this question is yes, denied.
If the answer to this question is no, List number of dose(s) go to question 21.
21. Is this request for a non-preferred drug? Y N
 The Texas Medicaid Preferred Drug List can be found at www.txvendordrug.com
If the answer to this question is yes, go to question 22.
If the answer to this question is no, approve for one month up to 5 doses during RSV season.
22. Has the patient had a treatment failure with a preferred drug within any subclass or a Y N
 contraindication or allergic reaction to any preferred drugs?
If yes, please list which drug, dates tried, and describe treatment failure, contraindication or allergy.

If no, denied.

Comments:

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

Prescriber (or Authorized) Signature

Date