# Fee-For-Service Medicaid Synagis Prior Authorization Request Form

2016-17

**Section I – Dispensing Pharmacy Information**

| Pharmacy Name | NPI | Phone | Fax |
|---|---|---|---|
| Maxor Specialty | 1871693119 | 866-629-6779 | 866-217-8034 |

**Section II – Patient Demographics**

| Name | Medicaid ID | Date of Birth | Gestational Age |
|---|---|---|---|
| | | | ____ weeks and ____/ 7th day |
| **Address** | | | **County of residence** |

Has patient received a Synagis prophylactic injection during hospitalization since the start current of the RSV season?

☐ No ☐ Yes If yes, number of shots: _____ Dose (mg): _____ Date(s): _____

Has the patient been hospitalized due to RSV at any time since the start of the current RSV season?

☐ No ☐ Yes If yes, date of diagnosis _____

**Section III – Patient Diagnosis at the start of the RSV season** (*Diagnoses/conditions must be clearly documented in the client's medical record.)*

| | |
|---|---|
| ☐ Patients who are **younger than 24 months** chronological age can qualify, for up to 5 monthly doses of Synagis, based on diagnosis listed to the right | ☐ **24-1:** Profoundly immunocompromised during the RSV season (solid organ or hematopoietic stem cell transplant, chemotherapy or other condition that leaves the infant profoundly immunocompromised ): ICD-10-CM code: |
| ☐ Patients who are **between 12 - 24 months** chronological age at the start of the RSV season can qualify, for up to 5 monthly doses of Synagis, based on the diagnosis or conditions listed to the right<br><br>** Please refer to page 3 for definition* | ☐ **24-2:** Active diagnosis of chronic lung disease (CLD) of prematurity#, **AND r**equired any of the following therapies within the 6 months prior to the current RSV season (check all that apply): ICD-10-CM code:<br>☐ Chronic systemic corticosteroids ☐ > 21% Supplemental oxygen<br>☐ Bronchodilator therapy ☐ Long-Term Mechanical Ventilator<br>☐ Diuretics |
| | ☐ **24-3:** Diagnosis of cystic fibrosis with severe lung disease*, or cystic fibrosis with weight for length less than the 10th percentile: ICD-10-CM code: |
| ☐ Patients who are **younger than 12 months** chronological age at the start of the RSV season can qualify, for up to 5 monthly doses of Synagis, based on criteria listed to the right. | ☐ **12-1**: ≤ 28 6/7 weeks gestational age at birth: ICD-10-CM code: |
| | ☐ **12-2**: Chronic lung disease (CLD) of prematurity#: ICD-10-CM code: |
| | ☐ **12-3**: Severe congenital abnormality of airway **OR** severe neuromuscular disease that impairs the ability to clear secretions from the upper airway because of ineffective cough: ICD-10-CM code: |
| | ☐ **12-4**: Active diagnosis of hemodynamically significant congenital heart disease (CHD): ICD-10-CM code:<br>**AND any of the below**<br>☐ Moderate to severe pulmonary hypertension.<br>☐ Acyanotic heart disease, on medication to control congestive heart failure, and will require cardiac surgery<br>☐ Cyanotic heart disease (with consultation from a pediatric cardiologist)<br>(NOTE: This excludes infants with hemodynamically insignificant heart disease - refer to page 3 for list) |
| | ☐ **12-5:** Diagnosis of cystic fibrosis with clinical evidence of CLD and/or nutritional compromise ICD-10-CM code: |

**Section IV – Synagis Prescription (to be completed by prescriber)**

**Rx:** Synagis (palivizumab) injection **Quantity:**_____ **Dose** (mg): _____ **Refills:** _____

**Sig:** Inject 15mg/kg one time per month **Current Weight:**_____ ☐ (kg) or ☐ (lbs.) **Date Weight Obtained:** _____

☐ Syringes 1ml 25G 5/8" ☐ Syringes 3ml 20G 1" ☐ Epinephrine 1:1000 amp. Sig: Inject 0.01mg/kg as directed.

| Prescriber Name | License number | NPI |
|---|---|---|
| **Address, City, State & ZIP** | **Phone** | **Fax** |
| **Physician Signature** | | **Date** |

**Fax the completed prior authorization form to 1-866-469-8590.**

**Clear Form**