



## 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:		Date Weighed:	
Last Palivizumab Dose:		Gestational Age:	

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"> <li>• Chronic use of corticosteroids</li> <li>• Diuretics</li> <li>• 21% Supplemental oxygen</li> <li>• Long-term mechanical ventilator</li> <li>• Bronchodilator therapy</li> </ul> <p><i>If the answer to this question is yes, go to question 19.</i><br/> <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><br/> <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><br/> <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"> <li>• 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)</li> <li>• Weight less than the 10th percentile</li> </ul> <p><i>If the answer to this question is yes, go to question 19.</i><br/> <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"> <li>• Clinical evidence of chronic lung disease</li> <li>• Nutritional compromise</li> </ul> <p><i>If the answer to this question is yes, go to question 19.</i><br/> <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 (<math>\leq</math>) 28 6/7 weeks?</p> <p><i>If the answer to this question is yes, go to question 18.</i><br/> <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><br/> <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><br/> <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><br/> <i>If the answer to this question is no, go to question 14.</i></p>  |   |   |
| 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><br/> <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><br/> <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 profoundly immunocompromised? Y N  
  - 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 today? Y N  
*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](http://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 contraindication or allergic reaction to any preferred drugs? Y N  
*If yes, please list which drug, dates tried, and describe treatment failure, contraindication or allergy.*

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*If no, denied.*

Comments:

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

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Prescriber (or Authorized) Signature

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Date