SYNAGIS® (palivizumab)	**SYNAGIS Prior Authorization Worksheet/Prescription Order Form.** Please FAX this completed form to Ohio Medicaid 800-396-4111	**Use this form ONLY for Medicaid when Synagis will be administered in the patient's home. No PA is required for fee-for-service Medicaid patients when Synagis is administered in the provider setting.services.**

PATIENT INFORMATION (BOLD ITEMS ARE REQUIRED)

Patient's (Child's) Name: ______________________ ☐ M ☐ F DOB:______

Gestational Age (GA) ____Weeks ______Days Birth Weight ______ lb/kg Current Weight ______lb/kg Date: ________

Patient's Address: ______________________ Daytime Phone: (___) ______________________

City/State/Zip: ______________________ Evening Phone: (___) ______________________

Parent's Name:______________________ Cell Phone: (___) __________ Best Time to Call:______

Member I.D. Number: ______________________Other Insurance:______________________

Synagis criteria are based on 2009 American Academy of Pediatrics Red Book Guidelines.

MEDICAL AUTHORIZATION CLINICAL CRITERIA (Please check ALL that apply.)

	Infant/Child's Condition
☐	≤ 28 6/7 weeks GA (≤ 12 months of age at start of RSV season) [5 dose max]
☐	29 0/7 – 31 6/7 weeks GA (≤ 6 months of age at start of season) [5 dose max]
☐	32 0/7 - 34 6/7 weeks GA (<3 months of age at start of RSV season); check all risk factors that apply [3 dose max up to age 90 days]
☐	Other - Explain:

Risk Factors Consideration

☐ Siblings < 5 years of age

☐ On O_2 /Airway Support

☐ Child Care Attendance

Diagnosis for Consideration (Please Check ALL that apply.)

☐ Immunosuppressive/autoimmune disease

☐ Severe Neuromuscular Disease

☐ Congenital Abnormalities of Airways

☐ Other ______________________

Please note:

Risk Factors for Consideration are subject to clinical and medical review

☐ 770.7

(Please document treatment and attach supporting documentation) →

Chronic Lung Disease/BPD: Infants and children ≤ 24 months with Chronic Lung Disease (CLD) who have received treatment for the medical condition in the 6 months prior to RSV season.

Diagnosis: ______________________

Treatment:

Mechanical ventilation:	yes / no	Days/Duration ______________
Supplemental oxygen:	yes / no	Days/Duration ______________
Steroids and/or diuretics:	yes / no	Days/Duration ______________
Other	yes / no	Days/Duration ______________

☐ ______ (745–747)

Cardiac (CHD) – Hemodynamically Significant: Infants and children ≤ 24 months with hemodynamically significant cyanotic & acyanotic heart disease

with moderate to severe pulmonary hypertension -747.83 or ______

with cyanotic congenital heart disease -746.9 or ______

who are receiving medication to control congestive heart failure -779.89_____ List medications:

Other______________________Dx ICD-9______________________

Comments: ______________________

PRESCRIBER INFORMATION (REQUIRED)

Prescriber's Name: ______________________ Medicaid TIN #______________ DEA#______________

Practice Name:______________________ NPI: ______________

Address______________________City______________ State________ Zip__________

Phone______________ Fax: ______________ Synagis Contact: ______________

RX INFORMATION SPECIAL INSTRUCTIONS:______________________

☐ **Synagis®** (palivizumab) 50 mg and/or 100 mg vials **Sig:** Inject 15 mg/kg IM one time per month ________ **# Doses**

Date for first Injection: __________ **Delivery to:** ☐ **Patient's Home** ☐ **MD Office**

Prescriber's Signature:______________________ **Date:**______________

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Fax: (800) 396 - 4111 HELPDESK: (877) 518 - 1546
Hours: Monday - Friday 7:00 am- 7:00 pm EST.