



# Synagis Prior Authorization Request Form

(KY -MAP-82101, revised 6/1/10)

Synagis® authorizations will not be issued to allow for therapy dates before November 1<sup>st</sup> and after March 31<sup>th</sup>  
Fax 800-365-8835 For URGENT Requests Only, FAX to 800-421-9064

Pt. Medicaid ID #: \_\_\_\_\_ Patient Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Pt. Gestational Age: Weeks\* \_\_\_\_\_ AND Days\* \_\_\_\_\_ \* Weeks AND Days required  
 Current Weight: \_\_\_\_\_ kg/lb Date recorded: \_\_\_\_\_  
 Prescriber Name: \_\_\_\_\_ Provider Specialty: \_\_\_\_\_  
 Prescriber NPI: \_\_\_\_\_ Prescriber Address: \_\_\_\_\_  
 Direct Phone: \_\_\_\_\_ Fax reply to: \_\_\_\_\_  
 Person Completing Form: \_\_\_\_\_  
Name title  
 Pharmacy Name: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_ NPI: \_\_\_\_\_  
 Fax to above or mail to: Pharmacy Department, 1<sup>st</sup> floor South, 14100 Magellan Plaza, Maryland Heights, MO 63043

### Clinical Criteria Documentation

**Diagnosis of Chronic Lung Disease** (formerly called bronchopulmonary dysplasia) **AND**

Child must be < 24 mos. of age at onset of season on Nov. 1st (DOB after 11/01/07) **AND** required medical treatment in the preceding 6 months. Check all therapies that may apply:

- Oxygen Most recent date administered \_\_\_\_\_
- Corticosteroids Most recent date administered \_\_\_\_\_
- Bronchodilators Most recent date administered \_\_\_\_\_
- Diuretics Most recent date administered \_\_\_\_\_

**Hemodynamically significant cyanotic or acyanotic congenital heart disease, (CHD) AND**

Child must be <24 mos. of age at onset of season on Nov. 1st (DOB after 11/01/07)

- Congestive Heart Failure or Cardiomyopathy; Meds. \_\_\_\_\_
- Moderate to severe Pulmonary Hypertension; Meds. \_\_\_\_\_
- Cyanotic heart disease; Meds \_\_\_\_\_
- Cardio-pulmonary bypass surgery; Date \_\_\_\_\_

**Child is ≤ 12 months of age on Nov. 1st ( DOB after 10/31/08) AND**

- Gestational age ≤ 28 weeks, 6 days, **OR**
- Gestational age ≤ 34 weeks, 6 days **AND**
  - Congenital abnormalities of the airway **OR**
  - Neuromuscular condition requiring handling of respiratory secretions

**Child is ≤ 6 months of age on Nov. 1st (DOB after 4/30/09) AND gestational age is 29 weeks, 0 days through 31 weeks, 6 days.**

**Child is ≤ 3 months of age on Nov. 1st (DOB after 7/31/09) AND gestational age is 32 weeks, 0 days through 34 weeks, 6 days\*, AND:**

- Child attends daycare, defined as a home or facility where care is provided for any number of infants or young toddlers **OR:**
- Child has a sibling <5 yrs of age

\*Children in this category will qualify for monthly doses only up until 3 mos. of age

**Signature of submitter \*\*** \_\_\_\_\_ **Date:** \_\_\_\_\_ On behalf of the Prescriber or Pharmacy Provider, I \*\*certify that the information stated above is a true statement, made for the purposes of inducing Kentucky Medicaid to offer prescription coverage to this individual for the medication requested above. I understand that Magellan Medicaid Administration, on behalf of the Commonwealth, will retain this document and any attached materials for the purposes of possible future audit(s).

*This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.*