

Kentucky Medicaid Prior Authorization Request Form

Synagis

Synagis® authorizations will not be issued to allow for *therapy dates* before November 1, 2012 and after March 31, 2013

Fax this signed, completed form to: (800) 365-8835

Questions? Call Magellan Medicaid Administration at (800) 477-3071

Or mail this request to: Medicaid PA Unit, 14100 Magellan Plaza, Maryland Heights, MO 63043

Revised 9/20/12

REQUESTOR	Person Completing Form: _____		Title: _____
RECIPIENT	Last Name, First Name, Middle I.: _____		
DOB: _____	Medicaid ID: _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Gestational Age: Weeks*: _____ and Days* _____ *Weeks and days required Current Weight: kg or lb _____			
PRESCRIBER	Name: _____	NPI: - - - - -	
Phone: () _____	Fax: () _____		
PHARMACY	Name: _____	NPI: - - - - -	
Phone: () _____	Fax: () _____		
REQUEST	Synagis 50mg NDC 60574411401 QTY - _____	PA Start Date	/ /
	Synagis 100mg NDC 60574411301 QTY - _____	PA Start Date	/ /

RATIONALE FOR PRIOR AUTHORIZATION *All sections must be completed or the request will not be approved*

[] Diagnosis of Chronic Lung Disease (formerly called bronchopulmonary dysplasia) **AND** child must be < 24 months of age at onset of season on Nov. 1st (DOB after 11/1/10) **AND** child has required medical treatment in the preceding 6 months.

Check/Complete all that 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 months of age at onset of season on Nov. 1st 28 (DOB after 11/1/010). Check/Complete all that apply:

- Congestive Heart Failure or Cardiomyopathy; Medications: _____
- Moderate to severe Pulmonary Hypertension; Medications: _____
- Cyanotic Heart Disease; Medications: _____
- Cardio-pulmonary bypass surgery; Date: _____

[] Child is ≤ 12 months of age on November 1st (DOB after 10/31/11) **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 4/30/12) **AND** gestational age is 29 weeks, 0 days through 31 weeks, 6 days.

[] Child is ≤ 3 months of age on Nov. 1st (DOB after 7/31/12) **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 resides in a home with another child < 5 years of age

*The infant in this category will qualify for monthly doses **only** up until 3 months of age.*

Signature of Submitter**	Date
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****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).**

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