Synagis Prior Authorization Request Form

(KY -MAP-82101, revised November 2010)

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

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, 1st 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 **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

- ☐ 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 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 AND**
-gestational age is 29 weeks, 0 days through 31 weeks, 6 days.

☐ **Child is ≤ 3 months of age on Nov. 1st 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.