

Synagis®

For RSV Season November 28, 2016 through May 15, 2017

Fax this request to: 1-888-603-7696

Questions: Call Magellan Medicaid Administration at 800-331-4475

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

If the following information is not complete, correct, or legible, the PA process can be delayed. Use one form per member, please.

Member Information

LAST NAME:

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FIRST NAME:

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ID NUMBER:

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DATE OF BIRTH:

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SEX: Male Female

Prescriber Information

LAST NAME:

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FIRST NAME:

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NPI NUMBER:

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PHONE NUMBER:

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FAX NUMBER:

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Request

Synagis® 50 mg NDC 60574411401 QTY: _____ Requested Start Date: _____ / _____ / _____

Synagis® 100 mg NDC 60574411301 QTY: _____ Requested Start Date: _____ / _____ / _____

Rationale for Prior Authorization (<http://dhss.alaska.gov/dhcs/Pages/pharmacy/medpriorauthoriz.aspx>)

Gestational age: _____ Weeks _____ Days *Note: Weeks and days are both required.* Weight in kilograms: _____

- Diagnosis of Chronic Lung Disease** (formerly called bronchopulmonary dysplasia) **AND** child must be < 24 months of age at onset of season on Nov. 28 (DOB after 11/28/2014) **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: ___ / ___ / ____
 - Other – most recent date administered: ___ / ___ / ____

The child may be approved for no more than 5 monthly doses of palivizumab.

- Hemodynamically significant cyanotic or acyanotic Congenital Heart Disease (CHD)** **AND** child must be ≤ 24 months of age at onset of season on November 28 (DOB on or after 11/28/2014). *The child may be approved for no more than 5 monthly doses of palivizumab. If the child undergoes cardio-pulmonary bypass surgery during the RSV season, an extra post-operative dose can be authorized.*
 - Cardio-pulmonary bypass surgery; Date: ___ / ___ / ____

- Child is < 12 months of age on November 28** (DOB after 11/28/2015); **AND**
 - Gestational age ≤ 28 weeks, 6 days; **OR**
- Child is < 12 months of age on November 28** (DOB after 11/28/2015) **AND** diagnosed with:
 - Congenital abnormalities of the airway; **OR**
 - Neuromuscular condition requiring handling of respiratory secretions. *The child may be approved for no more than 5 monthly doses of palivizumab.*

- Child is < 6 months of age on Nov. 28** (DOB after 5/28/2016) **AND** gestational age is 29 weeks, 0 days through 31 weeks, 6 days. *The child may be approved for no more than 5 monthly doses of palivizumab.*

- Child is < 3 months of age on Nov. 28** (DOB on 9/1/2016 or after) **AND** gestational age is 32 weeks, 0 days through 34 weeks, 6 days, **AND**:
 - Child attends daycare; **OR**
 - Child resides in a home with another child < 5 years of age; **OR**
 - Child resides in a crowded living environment (≥ 3 children per bedroom or ≥ 7 people per household); **OR**
 - Child resides in a home with lack of running water.

*The child in this category will qualify for monthly doses **only** up until 3 months (90 days) of age.*

Prescriber's Signature _____

Date: _____

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