Synagis® Prior Authorization Form

(palivizumab)

West Virginia Medicaid
Drug Prior Authorization Form

http://www.dhhr.wv.gov/bms/Pharmacy/Pages/default.aspx

Rational Drug Therapy Program
WVU School of Pharmacy
PO Box 9511 HSCN
Morgantown, WV 26506
Fax: 1-800-531-7787
Phone: 1-800-847-3859

Patient Name (Last) | (First) | (M) | WV Medicaid 11 Digit ID# | Date of Birth (MM/DD/YYYY)

Prescriber Name (Last) | (First) | (MI)

Prescriber Address (Street) | (City) | (State) | (Zip)

Prescriber 10-Digit NPI# | Phone # (111-222-3333) | Fax # (111-222-3333)

Pharmacy Name (if applicable)

Pharmacy Address (Street) | (City) | (State) | (Zip)

Pharmacy 10-Digit NPI# | Phone # (111-222-3333) | Fax # (111-222-3333)

Important Notes: Preauthorization for medical necessity does not guarantee payment.
The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

Please check applicable indication. Supporting documentation is required for all indications.

Infant / Child Age at Start of RSV Season	Criteria
≤ 12 months (1st year of life)	☐ Gestational Age (GA) <29 weeks, 0 days and otherwise healthy
	☐ Chronic Lung Disease (CLD) of prematurity (GA <32 wks, 0 days requiring >21% supplemental O_2 x first 28 days after birth.)
	☐ Anatomic pulmonary abnormalities, or neuromuscular disorder, or congenital anomaly that impairs the ability to clear secretions.
	☐ Profoundly immunocompromised
	☐ Cystic Fibrosis (CF) with CLD and/or nutritional compromise
	☐ Congestive Heart Failure (CHF) (hemodynamically *significant*) with *acyanotic* Heart Disease (HD) on CHF medications and who will require cardiac surgery or who have moderate to severe Pulmonary Hypertension (PH). For *cyanotic* heart defects, consult a pediatric cardiologist.
> 12 months to ≤ 24 months (2nd year of life)	☐ CLD of prematurity (GA <32 wks, 0 days requiring >21% supplemental O_2 x first 28 days after birth) and medical support (chronic systemic steroids, diuretic therapy, or supplemental O_2) within 6 months before start of 2nd RSV season.
	☐ CF with severe lung disease or weight for length <10th percentile
	☐ Cardiac transplant during RSV season
	☐ Already on prophylaxis and eligible: give post-op dose after cardiac bypass or after ECMO
	☐ Profoundly immunocompromised.

Drug Name:
palivizumab - (Synagis®)

Dose

Current Weight (in kg)

ICD Diagnosis Code (if available)

Were any doses previously administered to the patient for the current RSV season (November 1st)? ☐ Yes ☐ No

Date Administered:

Gestational Age Weeks Days

Chronological Age

Is the patient currently in the hospital? ☐ Yes ☐ No

Has the patient been in the hospital since the start of the current RSV Season (November 1st)? ☐ Yes ☐ No

If yes, were any doses of Synagis® administered while patient was hospitalized? ☐ Yes ☐ No

If yes, please provide date:

Medical justification / Reference attached supporting documentation (attach additional pages if necessary)

Medications (include medication name, start date and end date for diagnoses that require acceptable medical therapy (attach additional pages if necessary)

Other Pertinent Information (attach additional pages if necessary)

Attestation: Your signature (manually or electronically) certifies that the above request is medically necessary, does not exceed the medical needs of the member, and is documented in your medical records. Medical/Pharmacy records must be made available upon request.

☐ Check here for electronic signature

Prescriber or Pharmacist Signature

Date: (MM/DD/YYYY)