

# OHIO DEPARTMENT OF MEDICAID

## Prior Authorization Form Synagis® (palivizumab)

Request Date: \_\_\_/\_\_\_/\_\_\_

*(Criteria Based on 2014 American Academy of Pediatrics Red Book Guidelines)***\*\*\*Supporting Documentation is REQUIRED for Synagis Request\*\*\***

<b>Patient Medicaid ID#:</b> _____ Child's Name: _____ <input type="checkbox"/> M <input type="checkbox"/> F Patient DOB: ___/___/___ Age as of Nov 1 <sup>st</sup> : _____ Gestational Age: Weeks _____ Days _____ Birth Weight (kg): _____ Current Weight (kg): _____	<b>Prescriber's Full Name:</b> _____  Provider NPI #: _____  Prescriber Ph#: _____ Prescriber Fax#: _____
<b>If Known</b> Pharmacy Name: _____ Pharmacy Ph#: _____	

**DIAGNOSIS AND PATIENT HISTORY (CHECK ALL THAT APPLY):**

- Prematurity (gestational age 28 weeks, 6 days or less)
- Chronic lung disease of prematurity during 1<sup>st</sup> year of life ( $\leq 12$  months of age) ICD-10 code required: \_\_\_\_\_  
*<32 weeks GA requiring >21% of oxygen for at least the first 28 days after birth.*
- Chronic lung disease of prematurity during 2<sup>nd</sup> year of life ( $< 24$  months of age) ICD-10 code required: \_\_\_\_\_  
*<32 weeks GA requiring >21% of oxygen for at least the first 28 days after birth.*  
*Requirement for continued medical support (e.g. chronic corticosteroid, bronchodilator, or diuretic therapy; supplemental oxygen) during 6-month period before start of second RSV season*
- Treatment:**  
Oxygen (dates/duration \_\_\_\_\_) Steroids (dates/duration \_\_\_\_\_)  
Bronchodilators (dates/duration \_\_\_\_\_) Diuretics (dates/duration \_\_\_\_\_)
- Hemodynamically significant CHD during 1<sup>st</sup> year of life ( $< 12$  months of age) ICD-10 code required: \_\_\_\_\_
- Diagnosis of hemodynamically significant acyanotic CHD?  Yes  No
  - Diagnosis of hemodynamically significant cyanotic CHD?  Yes  No
    - Consultation with a pediatric cardiologist regarding palivizumab?  Yes  No
  - Diagnosis of moderate-to-severe pulmonary HTN?  Yes  No
  - List of medications used to control CHF \_\_\_\_\_
- Severe neuromuscular disease ( $\leq 12$  months of age) ICD-10: \_\_\_\_\_
- Receiving chemotherapy (check if patient is receiving chemotherapy)
- Congenital abnormalities of airways ( $\leq 12$  months of age) ICD-10: \_\_\_\_\_
- Undergoing cardiac transplantation ( $\leq 24$  months of age) Date \_\_\_\_\_
- Immunosuppressive/autoimmune disease ( $\leq 24$  months of age) ICD-10 required: \_\_\_\_\_
- Other: \_\_\_\_\_

<b>Rx info:</b> Synagis (palivizumab) 50mg and/or 100mg vials	Directions: Inject 15mg/kg IM one time per month
# Doses: _____ Date of first injection: _____	Qty: _____ Refills: _____

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(or agent of Prescriber)

Fax To: OHIO Department of Medicaid

Fax: (800) 396 - 4111 PA Helpdesk: (877) 518 - 1546

Revised: (5/2016)

Hours: Monday – Friday 8:00 am – 8:00 pm EST