OHIO DEPARTMENT OF MEDICAID

PRIOR AUTHORIZATION SYNAGIS *(palivizumab)*

(Criteria Based on 2014 American Academy of Pediatrics Red Book Guidelines)

*****Supporting Documentation is REQUIRED for Synagis Request*****

Request Date		Review Type Requested ☑ Standard ☐ Urgent
Individual's Medicaid ID Number		Prescriber's Full Name
Individual's Name		Prescriber's NPI Number
☐ Male ☐ Female	Gestational Age at Birth: Weeks Days	Prescriber's Phone Number
Individual's Date of Birth	Current Weight (kg)	Prescriber's Fax Number
(If Known) Pharmacy's Name		Pharmacy's Phone Number

DIAGNOSIS AND INDIVIDUAL HISTORY *(CHECK ALL THAT APPLY)*

Diagnosis and ICD-10 *(REQUIRED)*

☐ Prematurity *(gestational age 28 weeks, 6 days or less)*

☐ Chronic lung disease of prematurity during 1st year of life *(< 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 2nd 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* and continued medical support *(e.g. chronic corticosteroid, bronchodilator, or diuretic therapy; supplemental oxygen)* during 6-month period before start of second RSV season

☐ **Hemodynamically significant CHD during 1st year of life** *(< 12 months of age)*

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

Severe neuromuscular disease (< 12 months of age)

☐ Congenital abnormalities of airways (< 12 months of age)

☐ Profoundly Immunocompromised (≤ 24 months of age)

☐ Has received cardiac transplantation (< 24 months of age) Date:

☐ Other

TREATMENT HISTORY *(CHECK ALL THAT APPLY)*

List of medications used to control CHF or pulmonary HTN:	
☐ Oxygen *(dates/duration)*	☐ Bronchodilators *(dates/duration)*
☐ Steroids *(dates/duration)*	☐ Diuretics *(dates/duration)*

Rx info: Synagis (palivizumab) 50mg and/or 100mg vials Directions: Inject 15mg/kg IM one time per month			
Number of Doses	Date of first injection	Quantity	Refills

☐ I attest that I am a member of the prescriber's staff in accordance with Ohio Administrative Code rule 5160-9-03, as applicable. Only the prescribing provider or a member of the prescribing provider's staff may request prior authorization.

_____ _____

Prescriber's Signature (or staff of prescriber) Date

_____

IF a staff member is attesting, please print your name

Fax To: OHIO Department of Medicaid
Fax: (800) 396-4111 PA Helpdesk: (877) 518-1546
Hours: Monday-Friday 8:00 am – 8:00 pm EST