

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		
Patient Medicaid ID Number		Prescriber's Full Name
Child's Name		Provider NPI Number
<input type="checkbox"/> Male <input type="checkbox"/> Female	Gestational Age: Weeks Days	Prescriber Phone Number
Patient Date of Birth	Birth Weight (kg)	Prescribers Fax Number
Age as of November 1st	Current Weight (kg)	
(If Known) Pharmacy Name		Pharmacy Phone Number

DIAGNOSIS AND PATIENT HISTORY (CHECK ALL THAT APPLY)

<input type="checkbox"/> Prematurity (gestational age 28 weeks, 6 days or less) <input type="checkbox"/> 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. <input type="checkbox"/> 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. 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
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Treatment

Oxygen (dates/duration)	Steroids (dates/duration)
Bronchodilators (dates/duration)	Diuretics (dates/duration)
<input type="checkbox"/> Hemodynamically significant CHD during 1st year of life (< 12 months of age) ICD-10 code required	
Diagnosis of hemodynamically significant acyanotic CHD? <input type="checkbox"/> Yes <input type="checkbox"/> No	Diagnosis of hemodynamically significant cyanotic CHD? <input type="checkbox"/> Yes <input type="checkbox"/> No
Consultation with a pediatric cardiologist regarding palivizumab? <input type="checkbox"/> Yes <input type="checkbox"/> No	Diagnosis of moderate-to-severe pulmonary HTN? <input type="checkbox"/> Yes <input type="checkbox"/> No
List of medications used to control CHF	
<input type="checkbox"/> Severe neuromuscular disease (< 12 months of age) ICD-10 <input type="checkbox"/> Congenital abnormalities of airways (< 12 months of age) ICD-10 <input type="checkbox"/> Immunosuppressive/autoimmune disease (≤ 24 months of age) ICD-10 required: <input type="checkbox"/> Receiving chemotherapy (check if patient is receiving chemotherapy) <input type="checkbox"/> Undergoing cardiac transplantation (< 24 months of age) Date <input type="checkbox"/> Other	
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 office in accordance with OAC 5160-9-03.
 Only the prescribing provider or a member of the prescribing providers staff may request prior authorization.

Prescriber's Signature (or staff of Prescriber & PRINTED name) _____ Date: _____

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