Reset Form Print Form

Prior Authorization Form

Synagis®

Fax this form to: 1-800-424-3260

A fax cover sheet is not required.

Instructions: Please fill out all applicable sections on all pages completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the prior authorization). **Information contained in this form is Protected Health Information under HIPAA**.

☐ **NON-URGENT** ☐ **EXIGENT CIRCUMSTANCES**

MEMBER INFORMATION

Member's Last Name:

Member's First Name:

Member's Identification Number:

Date of Birth: – –

PRESCRIBER INFORMATION

Prescriber's Last Name:

Prescriber's First Name:

National Provider Identifier (NPI) Number:

DEA Number:

Office Phone Number: – –

Office Fax Number: – –

MEDICATION INFORMATION

Synagis® approvals may begin therapy **November 1st** with last date of therapy not to exceed **April 30th** (end of RSV season)

Strength: ☐ 50 mg ☐ 100 mg

Directions: _____

Member Weight: _____

Name of Dispensing Pharmacy: _____

NPI Number: _____

(Form continued on next page.)

Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

CLINICAL CRITERIA — Do **not** include documentation that is not requested on this form.

1. What is the member's gestational age? _____ weeks _____ days
2. Does the member have chronic lung disease of prematurity (formerly called bronchopulmonary dysplasia)?
   ☐ Yes ☐ No
   If **Yes**, go to question **2a**. If **No**, go to question **3**.
   a. Did the member receive oxygen immediately following birth?
      ☐ Yes ☐ No
      If **Yes**, go to question **2b**. If **No**, go to question **3**.
      What was the percentage oxygen received? _____
      What was the duration of treatment? _____
   b. Is the member is receiving any of the following respiratory support therapies daily?
      ☐ Oxygen Most recent date administered: _____
      ☐ Systemic corticosteroids Most recent date administered: _____
      ☐ Diuretics Most recent date administered: _____
3. Does the member have a diagnosis of cystic fibrosis?
   ☐ Yes ☐ No
   If **Yes**, go to question **3a**. If **No**, go to question **4.**
   a. Has the member been hospitalized for a pulmonary exacerbation?
      ☐ Yes ☐ No
      If **Yes**, what was the date of hospitalization? _____
   b. Does the member have clinical evidence of chronic lung disease?
      ☐ Yes ☐ No
   c. Does the member have clinical evidence of failure to thrive?
      ☐ Yes ☐ No
   d. Does the member have pulmonary abnormalities on chest x-ray or CT that persist when the member is stable?
      ☐ Yes ☐ No
   e. What is the member's weight for length percentile? _____
4. Does the member have any of the following?
   ☐ Anatomic pulmonary abnormality, specify:
   _____
   ☐ Neuromuscular disorder, specify:
   _____
   ☐ Congenital anomaly that impairs the ability to clear secretions, specify:
   _____

(Form continued on next page.)

 MHID: MRXCOM09_01

Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

5. Please indicate if member has any of the following:
   - ☐ Human immunodeficiency virus (HIV)
   - ☐ Cancer, receiving chemotherapy
   - ☐ Organ transplant receiving immunosuppressant therapy
   - ☐ Other medical condition severely immunocompromising member

   If **Other**, specify: _____

6. Has this member received a heart transplant?
   ☐ Yes ☐ No
   If **Yes**, include the date of transplant: _____

7. Does member have hemodynamically significant congenital heart disease?
   ☐ Yes ☐ No
   If **Yes**, please indicate which type of disease:
   - ☐ Acyanotic heart disease, specify: _____
   - ☐ Cyanotic heart disease, specify: _____

     Include the name of the pediatric cardiologist: _____
   - ☐ Pulmonary hypertension: _____
   - ☐ Other: _____

8. Will this member's congenital heart disease require cardiac surgery?
   ☐ Yes ☐ No

9. Please list any medications that may be used:
   - ☐ Ace-inhibitor/ARB — Most recent date administered: _____
   - ☐ Diuretic — Most recent date administered: _____
   - ☐ Beta-blocker — Most recent date administered: _____
   - ☐ Digoxin — Most recent date administered: _____
   - ☐ Other cardiovascular medications: — Specify: _____

10. If this is a request for a sixth dose of Synagis® during the respiratory syncytial virus (RSV) season, has the member had an extracorporeal membrane oxygenation (ECMO) or cardiac bypass during the RSV season?
    ☐ Yes ☐ No
    If **Yes**, include date: _____

(Form continued on next page.)

 MHID: MRXCOM09_01

Member's Last Name:

Member's First Name:

11. Is there any other information pertinent to this PA request?

☐ **Attachments**

_____ _____

Prescriber Signature (Required) ***Date***

(By signature, the Physician confirms the above information is accurate and verifiable by patient records.)

Fax this form to: 1-800-424-3260

Mail requests to:
Magellan Rx Management Prior Authorization Program
c/o Magellan Health, Inc.
4801 E. Washington Street
Phoenix, AZ 85034
Phone: 1-800-424-3312

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