maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Synagis

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	Is this request for the prevention or for the treatment of respiratory syncytial virus (RSV) disease? [] Prevention (If checked, go to 2) [] Treatment (If checked, no further questions)		
2	Does the patient have a contraindication to therapy (for example, a history of a severe prior reaction to Synagis or to other components of this product)? [If yes, no further questions.]	Yes	No
3	Will the child be 2 years of age or less at the start of the RSV season? [If no, no further questions.]	Yes	No

If you have any questions, call:
1-888-258-8250

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4	Is the patient 3 months of age or younger at the start of RSV season? [If no, skip to question 8.]	Yes	No
5	Was the patient born with a gestational age (GA) of 32 weeks 0 days to 34 weeks 6 days? [If no, skip to question 9.]	Yes	No
6	Does the patient attend childcare, defined as a home or facility in which care is provided for any number of infants or toddlers? [If yes, skip to question 17.]	Yes	No
7	Does the patient have 1 or more siblings, or other children, younger than 5 years that live permanently in the same household? [If yes, skip to question 17.] [If no, skip to question 9.]	Yes	No
8	Is the patient 6 months of age or younger at the start of RSV season? [If no, skip to question 10.]	Yes	No
9	Was the patient born with a gestational age (GA) of 29 weeks 0 days to 31 weeks 6 days? [If yes, skip to question 18.] [If no, skip to question 11.]	Yes	No
10	Is the patient 12 months of age or younger at the start of RSV season? [If no, skip to question 13.]	Yes	No
11	Was the patient born with a gestational age (GA) of less than or equal to 28 weeks? [If yes, skip to question 18.]	Yes	No
12	Does the patient have significant congenital abnormalities of the airway, or a neuromuscular condition that compromises handling of respiratory tract secretions? [If yes, skip to question 18.]	Yes	No
13	Does the patient have a diagnosis of chronic lung disease of prematurity (CLD), (formerly known as bronchopulmonary dysplasia [BPD])? [If no, skip to question 15.]	Yes	No
14	Has the patient required medical therapy with supplemental oxygen, bronchodilator, diuretic or chronic corticosteroid therapy for their CLD within 6 months prior to RSV season? [If yes, skip to question 18.]	Yes	No
15	Does the patient have a diagnosis of hemodynamically significant cyanotic or acyanotic congenital heart disease (CHD)?	Yes	No

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[If no, no further questions.]

16 Is the patient receiving medication to control congestive heart failure, has moderate-severe pulmonary hypertension, or cyanotic heart disease? Yes No
[If yes, skip to question 18.]
[If no, no further questions.]

17 How many doses has the patient received?
[] The patient has not received any doses of Synagis (If checked, no further questions)

[] 1 dose (If checked, no further questions)

[] 2 doses (If checked, no further questions)

[] 3 or more doses (If checked, no further questions)

18 How many doses has the patient received?
[] The patient has not received any doses of Synagis (If checked, no further questions)

[] 1 dose (If checked, no further questions)

[] 2 doses (If checked, no further questions)

[] 3 doses (If checked, no further questions)

[] 4 doses (If checked, no further questions)

[] 5 or more doses (If checked, no further questions)

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

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FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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