Synagis® - Prior Authorization Request Form

Commonwealth of Kentucky

Synagis® authorizations will not be issued to allow for therapy dates before November 1st and after March 31th

Pt. Medicaid ID #: |__|__|__|__|__|__|__|__|__|__|__| Patient Name:___ _____

DOB:_____ Pt. Gestational Age: **Weeks*_____AND** Days*_____ * Weeks **AND** Days required

Current Weight:_____ kg/lb Date recorded:_____

Prescriber Name:_____ Provider Specialty:_____

Prescriber NPI: |__|__|__|__|__|__|__|__|__|__| Prescriber Address:_____

Person Completing Form:_____
Name title

Direct Phone:_____ Fax reply to:_____

Pharmacy Name:_____ Pharmacy Phone:_____

Pharmacy NPI: |__|__|__|__|__|__|__|__|__|__| **Fax request(s) to: First Health Services Fax 800-365-8835**

Clinical Criteria Documentation

☐ **Diagnosis of Chronic Lung Disease** (formerly called bronchopulmonary dysplasia) **AND**
Child must be < 24 mos. of age at onset of season on Nov.1st (DOB after 11/01/07) **AND**
required medical treatment in the preceding 6 months. Check all therapies that may apply:

- ☐ Oxygen Most recent date administered_____
- ☐ Corticosteroids Most recent date administered_____
- ☐ Bronchodilators Most recent date administered_____
- ☐ Diuretics Most recent date administered_____

☐ **Hemodynamically significant cyanotic or acyanotic congenital heart disease, (CHD) AND**
Child must be <24 mos. of age at onset of season on Nov.1st (DOB after 11/01/07)

- ☐ Congestive Heart Failure or Cardiomyopathy; Meds._____
- ☐ Moderate to severe Pulmonary Hypertension; Meds._____
- ☐ Cyanotic heart disease; Meds_____
- ☐ Cardio-pulmonary bypass surgery; Date_____

☐ **Child is ≤ 12 months of age on Nov. 1st** (DOB after 10/31/08) **AND**

- ☐ Gestational age ≤ 28 weeks, 6 days, **OR**
- ☐ Gestational age ≤ 34 weeks, 6 days **AND**
  - ☐ Congenital abnormalities of the airway **OR**
  - ☐ Neuromuscular condition requiring handling of respiratory secretions

☐ **Child is ≤ 6 months of age on Nov. 1st** (DOB after 4/30/09) **AND**
gestational age is 29 weeks, 0 days through 31 weeks, 6 days.

☐ **Child is ≤ 3 months of age on Nov. 1st** (DOB after 7/31/09) **AND**
gestational age is 32 weeks, 0 days through 34 weeks, 6 days*, AND:

- ☐ Child attends daycare, defined as a home or facility where care is provided for any number of infants or young toddlers **OR:**
- ☐ Child has a sibling <5 yrs of age

*Children in this category will qualify for monthly doses only up until 3 mos. of age

Signature of submitter **_____ Date:_____

On behalf of the Prescriber or Pharmacy Provider, I **certify that the information stated above is a true statement, made for the purposes of inducing Kentucky Medicaid to offer prescription coverage to this individual for the medication requested above. I understand that First Health Services, on behalf of the Commonwealth, will retain this document and any attached materials for the purposes of possible future audit(s).