

SYNAGIS
PRIOR AUTHORIZATION FORM

To review the prior authorization guidelines for Synagis, please refer to Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter-Synagis (accessible at: <http://www.dhs.state.pa.us/publications/bulletinsearch/index.htm>)

PRIOR AUTHORIZATION REQUEST INFORMATION

New Renewal Additional Information (PA#: _____)
pages in this request: _____ Office Contact Name: _____ Phone: (____) _____

RECIPIENT INFORMATION

Name: _____ Recipient ID#: _____ Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Specialty: _____
NPI#: _____ OR MA Provider ID#: _____ State License#: _____
Prescriber Address: _____ Suite #: _____
City/State/Zip: _____ Phone: (____) _____ Fax: (____) _____

MEDICAL INFORMATION

Chronological Age: _____ **Gestational Age:** _____ weeks _____ days
Current Weight: _____ pounds _____ ounces = _____ kilograms (kg)
Synagis dose: (15 mg/kg/dose) x _____ kg = _____ mg
Number of Doses Requested: _____ months (maximum: 5 monthly doses)
Which Specialty Pharmacy will be utilized? Diplomat Specialty Pharmacy Walgreens Specialty Pharmacy
Check which criteria apply & provide supporting chart documentation (Pennsylvania RSV season begins November 1st):
 Infant born before 29 weeks gestation [28 weeks, 6 days or less] **AND** less than 12 months of age at the start of RSV season
 Infant less than 12 months of age at the start of RSV season with Chronic Lung Disease (CLD) of prematurity, defined as meeting **ALL** of the following:
 Born before 32 weeks gestation [31 weeks, 6 days or less]
 Required more than 21% oxygen for at least the first 28 days after birth
 Infant 12-24 months of age at the start of RSV season with CLD of prematurity, defined as meeting **ALL** of the following:
 Born before 32 weeks gestation [31 weeks, 6 days or less]
 Required more than 21% oxygen for at least the first 28 days after birth
 Continue to require medical support with at least **ONE** of the following treatments during the 6 month period before the start of the RSV season (check all treatments that apply and provide documentation of medications, dosages and last date of administration): Chronic corticosteroid Diuretic Supplemental oxygen
 Infant less than 12 months of age at the start of RSV season with a neuromuscular disease or congenital anomaly that impairs the ability to clear secretions from the upper airway because of ineffective cough – document condition: _____
 Infant less than 24 months of age at the start of RSV season and is profoundly immunocompromised (e.g. HIV, cancer, receiving chemotherapy) – document condition: _____
 Infant 12 months of age or younger at the start of RSV season with hemodynamically significant Congenital Heart Disease

PLEASE FAX COMPLETED FORM WITH CLINICAL INFORMATION TO DHS – PHARMACY DIVISION

Prescriber Signature: _____ **Date:** _____