Upper Peninsula Health Plan

Prior Authorization Form

Synagis®

Member Information

LAST NAME: | **FIRST NAME:**

ID NUMBER: | **DATE OF BIRTH:** ___ – ___ – ____

Prescriber Information

LAST NAME: | **FIRST NAME:**

NPI NUMBER: | **DEA NUMBER:**

PHONE NUMBER: ___ – ___ – ____ | **FAX NUMBER:** ___ – ___ – ____

Synagis® approvals may begin therapy **November 15th** with last date of therapy not to exceed **April 15th** (end of RSV season)

STRENGTH: ☐ 50 mg ☐ 100 mg **DIRECTIONS:** _____ **PATIENT WEIGHT:** _____

NAME OF DISPENSING PHARMACY: _____ **NPI NUMBER:** _____

Clinical Criteria Documentation ***Do **NOT** include documentation that is not requested on this form***

1. **What is the patient's gestational age? _____ weeks _____ days**
2. **Does the patient have Chronic Lung Disease of Prematurity (formerly called bronchopulmonary dysplasia).** If ***YES***, go to question **2a**. If ***NO***, go to **3**. ☐ Yes ☐ No
   a. **Did the patient receive oxygen immediately following birth?** If ***YES***, go to **2b**. If ***NO***, go to **3**. ☐ Yes ☐ No
   b. **Please indicate the % oxygen received : _____ Duration of treatment: _____**
   c. **Please indicate if patient is receiving any of the following respiratory support therapies on a daily basis:**
      - ☐ Oxygen Most recent date administered: _____
      - ☐ Systemic corticosteroids Most recent date administered: _____
      - ☐ Diuretics Most recent date administered: _____
3. **Does the patient have a diagnosis of Cystic Fibrosis?** If ***YES***, go to question **3a**. If ***NO***, go to **4**. ☐ Yes ☐ No
   a. **Has the patient been hospitalized for a pulmonary exacerbation? Date: _____** ☐ Yes ☐ No
   b. **Does the patient have clinical evidence of chronic lung disease?** ☐ Yes ☐ No
   c. **Does the patient have clinical evidence of failure to thrive?** ☐ Yes ☐ No
   d. **Does the patient have pulmonary abnormalities on chest x-ray or CT that persist when the patient is stable?** ☐ Yes ☐ No
   e. **What is the patient's weight for length percentile? _____**
4. **Please indicate if patient has any of the following:**
   - ☐ Anatomic Pulmonary Abnormality, specify: _____
   - ☐ Neuromuscular Disorder, specify: _____
   - ☐ Congenital anomaly that impairs the ability to clear secretions, specify: _____

LAST NAME: | | | | | | | | | | | | |

FIRST NAME: | | | | | | | | | | | | |

5. Please indicate if patient has any of the following:

- ☐ HIV
- ☐ Cancer, receiving chemotherapy
- ☐ Organ transplant receiving immunosuppressant therapy
- ☐ Other medical condition severely immunocompromising patient, specify: _____

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

7. Does patient 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 Name of Pediatric Cardiologist: _____
- ☐ Pulmonary Hypertension
- ☐ Other: _____

8. Will this patient'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 RSV season, has the patient had an ECMO or cardiac bypass during the RSV season? ☐ Yes ☐ No

If ***YES***, include date: _____

11. Please note any other information pertinent to this PA request:

_____ _____

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

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

Fax This Form to: 1-888-656-3604

Mail requests to: Magellan Rx Management
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Magellan Rx MANAGEMENT℠