

## MEDICATION PRIOR AUTHORIZATION REQUEST FORM FAX this completed form to 1-888-865-6531

OR Mail request to: Pharmacy Services Prior Authorization Dept. 5 River Park Place East, Suite 210 | Fresno, CA 93720

SYNAGIS® – All Florida Regions Combined Coverage Period: Based upon the specific region per the FLDOH website:

http://www.floridahealth.gov/diseases-and-conditions/respiratory-syncytial-virus/Maximum number of doses: 5

Note: Form must be completed in full. An incomplete form may be returned.

Red	cipie	nt's l	/ledic	aid I	ID#	1	1					Date	e of E	Birth	(MM	/DD/	ΥΥΥ	Y)		1		1							
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Syl	nagis	s Vial	Qty:				•																		_			•	
SIG: Inject 15 mg/kg IM once monthly  Start Date: Refill(s):mos										S																			
□ 100 mg □ 50 mg Birth Weight: □ □ lbs / □ kgs Current Weight: □																													
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	If > 1	2 mo	nths (	old a	nd < :	24 m	onth	s old																					
	Cys	stic Fil	orosis	3																									
	-				t leas	t one	of t	he fo	llow	ing cr	iteria																		
		☐ Nutritional compromise (weight for length < 10 <sup>th</sup> percentile)																											
	☐ Hospitalization for pulmonary exacerbation in first year of life																												
		Che	st X-r	ay oı	r CT a	abnoı	rmali	ties t	hat	persis	t wh	en st	able																
	Chr	onic I	ung c	lisea	se (G	6A < 3	32 w	eeks	and	l requ	ired (	oxyg	en fo	r at l	east	first 2	28 da	ys af	ter b	irth)									
	(Sp	ecify	Diagr	nosis	Code	e)																							
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Call 1-833-705-1351 to request a 72-hour supply of medication. Any dosage increase must have corresponding weight charts and/or progress notes with current weight. If the dose needed is less than 5 mg over the approved vial size, round down to the nearest vial size. If the dose needed is ≥ 5 mg over the approved vial size, then the new vial size will be approved. For those patients who are expected to gain enough weight to need an additional vial, please schedule a visit to obtain weight & receive approval for dose increase prior to the Synagis® administration date. There are no immediate approvals for "waiting" patients. In cases where immediate administration of medication is required, providers should use the currently authorized vial size(s), then submit a weight change request, which will be applied to subsequent dosages only. Pharmacy Services will respond via fax or phone within 24 hours of receipt of all necessary information, except during weekends and holidays. For immediate response on weekends and holidays, NurseWise will answer your call.



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	f ≤ 12 months old												
☐ Hemodynamically significant cyanotic or acyanotic congenital heart disease on medications to control CHF and will require													
	(Specify Diagnosis Code)												
	Moderate to severe pulmonary hypertension												
□ I	f < 12 months old												
	< 29 completed weeks gestational age at birth (otherwise healthy)												
Dia	gnosis Code: ICD 10: P07.21 – P07.26												
	Chronic lung disease* (GA < 32 weeks): (Specify Diagnosis Code)												
	AND: required supplemental oxygen (for at least first 28 days after birth)												
	*CLD is not asthma, croup, recurrent upper respiratory infections, chronic bronchitis, chronic bronchiolitis, or a history of a previous RSV infection.												
	Severe neuromuscular disease												
	(Specify Diagnosis code)												
	Congenital anomalies of the airways												
	(Specify Diagnosis code)												
	Profoundly immunocompromised												
	(Specify Diagnosis code)												
	Cystic Fibrosis with CLD and/or nutritional compromise												
Pre	scriber's Signature: Date:												
	REQUIRED FOR REVIEW: Copies of medical records (e.g., diagnostic evaluations and recent chart notes), the most recent copies of related labs, and supporting documentation for clinically appropriate submissions.  The provider must retain copies of all documentation for five years.												
On suk	NOTE: Pharmacies should not submit separate claims for different dosage strength vials to be administered on the same date. Only one compound claim submission will be necessary. For example, if the Synagis dosage is 150 mg, the pharmacy should submit a compound claim that lists the two different strength vials (100 mg and 50 mg).  Weight Criteria for Synagis® (palivizumab): (Refer to Weight Change Form)												
All	weights must be verified for dosing accuracy.												
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