

## MEDICATION PRIOR AUTHORIZATION REQUEST FORM FAX this completed form to 1-833-546-1507

OR Mail request to: Pharmacy Services Prior Authorization Dept.

5 River Park Place East, Suite 210 | Fresno, CA 93720

Call 1-866-399-0928 to request a 72-hour supply of medication.

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.

## **Synagis®**

## Weight Change Form

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

- 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.

Recipient's Medicaid ID#											Date of Birth (MM/DD/YYYY)																		
														1			1												
Recipient's Full Name													<u>.                                    </u>			]					]								
Prescriber's Full Name																													
		1			Ĭ																								
Pro	cri	ber's	NDI																										
1163	CII	Dei 3	INFI							1																			
	<u> </u>															<b>-</b> .		<b>I</b>											
Pres	scri	criber Phone Number									Prescrib							er Fa	IX NI	ımbe	er								
			_				-														-				-				
Pharmacy Name																													
Pharmacy Medicaid Provider #																													
Pha	harmacy Phone Number										Pharmacv I									Fax Number									
			] _				-														-				-				
•	1. Previous Weight: lbs or										kgs																		
2	2.	. Current Weight: lbs or _								or _	kgs																		
;	3. New Dose Required:																												
Pre	Prescriber's Signature:																	I	Date:										

REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years.

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (via return fax) immediately and arrange for the return or destruction of these documents. Distribution, reproduction or any other use of this transmission by any party other than the intended recipient is strictly prohibited.