sunshine health

# SPECIALTY MEDICATION PRIOR AUTHORIZATION FORM

Complete this form and send information to
Sunshine Health, Pharmacy Department fax at **1-866-351-7388**
For questions, please call **1-866-796-0530, Ext 41919**

## SYNAGIS® – All Florida Regions Combined

**Coverage Period: July 1st through April 30th**
**Maximum number of doses: 5**
**(No authorizations for May and June)**
**Note: Form must be completed in full. An incomplete form may be returned.**

Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY) ___ / ___ / ____

Recipient's Full Name

Prescriber's Full Name

Prescriber License # (ME, OS, ARNP, PA)

Prescriber Phone Number ___ - ____

Prescriber Fax Number ___ - ____

**Synagis Vial Qty:**
*SIG: Inject 15 mg/kg IM once monthly*
◯ 100 mg ◯ 50 mg

**Start Date:** _____

**Refill(s):** _____mos

**Birth Weight:** _____ ◯ lbs / ◯ kgs

**Current Weight:** _____ ◯ lbs / ◯ kgs

**Gestational Age (GA) :** _____

☐ If < 24 months old

☐ Cardiac transplant during RSV season

☐ Already on prophylaxis and eligible; give post-op dose after cardiac bypass or after ECMO

☐ Profoundly Immunocompromised (Specify Diagnosis Code)_____

☐ If > 12 months < 24 months old

☐ Cystic Fibrosis

**AND:** must meet at least one of the following criteria

- ☐ Nutritional compromise (weight for length < 10th percentile)
- ☐ Hospitalization for pulmonary exacerbation in first year of life
- ☐ Chest X-ray or CT abnormalities that persist when stable

☐ Chronic lung disease (GA< 32 weeks and required > 21% $O_2$ for at least first 28 days after birth):
(Specify Diagnosis Code) _____

**AND:** has required any of the following therapies within the past 6 months:

- ☐ Supplemental oxygen
- ☐ Mechanical ventilation
- ☐ Steroids (systemic or inhaled)
- ☐ Diuretics

*CLD is not asthma, croup, recurrent upper respiratory infections, chronic bronchitis, chronic bronchiolitis, or a history of a previous RSV infection.

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☐ If ≤ 12 months old

☐ < or = 29 completed weeks gestational age at birth (otherwise healthy)
Diagnosis Code: ICD 9: 765.21 – 765.24 ICD 10: P07.21 – P07.26

☐ Chronic lung disease* (GA< 32 weeks): (Specify Diagnosis Code) _____

☐ **AND:** required Supplemental oxygen (> 21% $O_2$ 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.

☐ Hemodynamically significant cyanotic or acyanotic congenital heart disease on medications to control CHF and will require surgery:
(Specify Diagnosis Code) _____

☐ Moderate to severe pulmonary hypertension

☐ 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

☐ If < 3 months old (no CLD, no CHD) (max of 3 doses)

Gestational Age of 29 weeks 1 day to 34 weeks, 6 days at start of RSV season:

Diagnosis Code: ICD 9: 765.25 – 765.27 ICD 10: P07.33 – P07.37
**WITH:** at least one of the following risk factors:
☐ Attends child care with multiple other children
☐ Siblings or other children less than 5 years old living permanently in the home

**Prescriber's Signature:** _____ **Date:** _____

**REQUIRED FOR REVIEW:** Copies of medical records (i.e., diagnostic evaluations and recent chart notes), a copy of the original prescription, and the most recent copies of related labs

**The provider must retain copies of all documentation for five years.**

**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 (100mg and 50mg).**

**Weight Criteria for Synagis® (palivizumab): (Refer to Weight Change Form)**

All weights must be verified for dosing accuracy.