OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY/MEDICAL PRIOR AUTHORIZATION REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request.** All other information may be filled in by office staff; **fax to 1-800-750-9692.** No additional phone calls will be necessary **if** all information (including phone and fax #s) on this form is correct**. Incomplete form will delay authorization process.**

Drug Requested: **SYNAGIS™** (palivizumab) **(90378) (Medical)**

Season: October 1 through March 31

DRUG INFORMATION: Complete information below or authorization process will be delayed.

Drug Form/Strength: _____

Diagnosis: _____ **ICD Code:** _____

Quantity Per Month/# of Doses Requested: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Patient's Weight: _____ **Patient's Date of Birth**: _____

Supporting documentation MUST be submitted with this request.

{Supporting documentation may include: copies of hospital discharge notes, progress notes, pharmacy profiles, etc., and **MUST** include all medications, frequency of medication dosing and diagnosis(es) with indications of severity of illness.}

CLINICAL CRITERIA: Check applicable age, condition, and risk factors below. If incomplete or box **not** checked, authorization may be delayed.

MAXMIMUM 5 DOSES (dosed until March 31st)

❑ Gestational age < 28 wks, 6 days **and** patient's CA < 12 months†	❑ Patient's CA < 24 months† old with Chronic Lung Disease* of prematurity (gestational age < 32 wks)
❑ Gestational age 29 wks, 0 days-31 wks, 6 days **and** patient's CA < 6 months†	❑ Patient's CA < 12 months† old with hemodynamically Congenital Heart Disease* (**without** surgical correction)
❑ Chronic lung disease of prematurity (gestational age 32 wks, 0 days) **and** patient's CA < 12 months old at start of RSV season **and** required > 21% oxygen for at least 28 days after birth	❑ Patient's CA < 24 months† old **and** severely immunocompromised
❑ Patient's CA < 12 months† with congenital abnormalities of the airway or neuromuscular disease that compromises handling of respiratory secretions*	**† Chronological age (CA) at start of RSV season** *** Include ICD-9 codes for the indicated disease states. For CLD/CHD, attach supporting documentation (i.e., progress notes, discharge notes, and/or chart notes).**

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AND

- Is the patient currently outpatient without an inpatient hospitalization within the last 2 weeks? ❑ Yes ❑ No

  If no, document the discharge date: _____

- Has the patient received any Synagis™ doses during the current RSV season? ❑ Yes ❑ No

  If yes, document the administration date(s): _____

Medical Justification/Documentation for diagnoses not listed above: attach support documentation.

_____

_____

_____

Medication being provided by (check applicable box below):

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy - PropriumRx**

Use of samples to initiate therapy does not meet step-edit/preauthorization criteria*

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: ~~8/1/2017~~; ~~7/5/2018~~; ~~8/30/2018~~; ~~10/8/2018~~; **12/4/2018**;