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 1-844-348-3720.** 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).**

(continued on next page)

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**;

Optima Health Community Care
And
Optima Family Care
(Medicaid)
Synagis® Prior Authorization Criteria

1. Is the infant's gestational age < 28 wks, 6 days and chronological age less than 12 months old?
   - ❑ Yes (If Yes, go to #8) ❑ No (If No, go to #2)
2. Is the infant's gestational age 29 wks up to 31 wks, 6 days and chronological age less than 6 months old?
   - ❑ Yes (If Yes, go to #8) ❑ No (If No, go to #3)
3. 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.
   - ❑ Yes (If Yes, go to #8) ❑ No (If No, go to #4)
4. Is the infant's chronological age < 12 months with a diagnosis of congenital abnormalities of the airway or neuromuscular disease that compromises handling of respiratory secretions? Supporting documentation* of diagnosis/ICD-10 code ***MUST*** be included.
   - ❑ Yes (If Yes, go to #8) ❑ No (If No, go to #5)
5. Is the patient less than 24 months of age with a diagnosis of Chronic Lung Disease (CLD) of prematurity (defined as gestational age less than 32 weeks) and has received medical therapy (supplemental oxygen [> 21% for at least 28 days, vent not required], diuretic, or chronic corticosteroid therapy) within 6 months before the start of the RSV season or who continue to require medical therapy (as defined above). Supporting documentation* of diagnosis./ICD-10 code and medical therapy ***MUST*** be included.
   - ❑ Yes (If Yes, go to #8) ❑ No (If No, go to #6)
6. Is the patient 12 months of age or younger with a diagnosis of hemodynamically significant Congenital Heart Disease (CHD) with one of the following:
   a. Congenital heart disease patient who is receiving medication to control congestive heart failure (CHF),
   OR
   b. Moderate to severe pulmonary hypertention[2], **OR**
   c. Cyanotic heart disease with no or incomplete surgical correction of defect[2]?

   Supporting documentation* of diagnosis/ICD-10 code as well as medications (if applicable) **MUST** be included.
   - ❑ Yes (If Yes for 6a, 6b or 6c, go to #8) ❑ No (If No, go to #7)
7. Is the patient less than 24 months of age and severely immunocompromised?
   - ❑ Yes (If Yes, go to #8)
   - ❑ No (If No, must be reviewed by Pharmacist or Medical Director)
8. Is the patient currently an outpatient and has not been enrolled as an inpatient within 2-weeks of the date the Synagis® is requested?

   Enter discharge date (if applicable) _____
   - ❑ Yes (If Yes, approve request)
   - ❑ No (If No, prior authorization **MUST** be given to be effective 2 weeks post-hospital discharge)

One of the first 6 criteria and the final criterion **MUST** be met before approval can be granted. Documentation of the hospital discharge summary from birth or documentation of the first office visit with pertinent information (gestational age, diagnosis, etc.) is required on all Synagis® PA requests. **RSV prophylaxis approval will terminate March 31**. **RSV season is defined by the Virginia Medicaid Agency as October 1 through March 31**.