OPTIMA HEALTH 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.

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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; **(REFORMATTED) 2/5/2019**