OPTIMA HEALTH COMMUNITY CARE

PHARMACY/MEDICAL PRIOR AUTHORIZATION/STEP-EDIT 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)**

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed. Supporting clinical documentation, i.e., office notes, hospital summary, etc., are required for clinical review.

Drug Form/Strength/Month: _____

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

Diagnosis: _____ **ICD Code:** _____

****Medical notes MUST be submitted to support each line checked on this request.****

CLINICAL CRITERIA: Check one below. If incomplete or box not checked, authorization process will be delayed. MAXIMUM 5 doses (dosed until March 31st).

- ❑ Born ***before*** the RSV season ***(Prior to September 30)*** ❑ Born ***during*** the RSV season ***(after October 1)***
  - ❑ **Infants with CLD (First year life)** born <32 weeks, 0 days' gestation and require >21% supplemental O_2 for at least 28 days after birth
  - ❑ **Infants with CLD (Second year life)** born <32 weeks, 0 days' gestation **AND** continued to require medical support: (chronic corticosteroids therapy, diuretic therapy, or supplemental oxygen).
  - ❑ **Infants without CLD or CHD** born <29 weeks, 0 days' gestation that are < 12 months at start of (RSV) season. **≥29 weeks, 0 days' gestation is *NOT RECOMMENDED*!**
  - ❑ **Infants with neuromuscular disorder or congenital pulmonary anomaly (First year life)** that impairs the ability to clear secretions from upper airway (Must have one of the following: ineffective cough, recurrent gastroesophageal tract reflux, pulmonary malformations, tracheoesophageal fistula, upper air way conditions, or requiring tracheostomy)
  - ❑ **Children with hemodynamically significant CHD** that were <12 months at onset of (RSV) season (i.e. infants with acyanotic CHD on meds to control CHF and require cardiac surgical procedure, **AND** infants with moderate-severe pulmonary hypertension) **OR** children <24 months who have undergone cardiac transplant during (RSV) season.

If approved, authorization will be given for a specific number of injections, to be ORDERED between October 1st and March 31st.

(signature on next page)

***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