OPTIMA HEALTH PLAN

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 1-844-202-5034. Supporting clinical documentation (office notes, hospital summary, etc.) are required for clinical review. 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)***

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**: ❑ **Briova SpecialtyRx**

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 #: _____

***Approved by Pharmacy and Therapeutics Committee:** 8/2010
REVISED/UPDATED: ~~6/3/2011~~; ~~9/12/11~~; ~~4/24/2012~~; ~~10/1/2012~~; ~~8/29/13~~; ~~2/26/2014~~; ~~8/13/2014~~; ~~8/15/14~~; ~~8/21/2014~~; ~~8/26/2014~~; ~~10/31/2014~~; ~~4/3/2015~~; ~~5/23/2015~~; ~~12/30/2015~~; ~~1/29/2016~~; ~~9/22/2016~~; ~~11/29/2016~~; ~~12/13/2016~~; ~~9/18/2017~~; **10/4/2017**