

OPTIMA HEALTH PLAN

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 1-844-202-5034. 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)

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

DRUG INFORMATION: Complete all information below or 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 to qualify. 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 O₂ 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.

(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**