

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 1-844-723-2094. 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 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.

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 #: _____

*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; 12/11/2016; 2/2/2017; 7/24/2017.