VERMONT

Department of Vermont Health Access
NOB 1 South, 280 State Drive
Waterbury, Vermont 05671-1010

~Synagis PA ~

Prior Authorization Request Form

In order for beneficiaries to receive Medicaid coverage for medications that require prior authorization, the prescriber must complete and fax this form to Change Healthcare. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information. For questions, please contact the Change Healthcare helpdesk at 1-844-679-5363.

Submit request via Fax: 1-844-679-5366

Prescribing physician:
Name: ___________________________________
Physician NPI: ____________________________
Specialty: _________________________________
Phone#: __________________________________
Fax#: ____________________________________
Address: _________________________________
Contact Person at Office: ___________________

Beneficiary:
Name: ____
Medicaid ID#: ____
Date of Birth: _________________________ Sex: ___________
Patient's Phone: _______________________________________
Pharmacy Name_______________________________________
Pharmacy NPI: ____
Pharmacy Phone: _____________Pharmacy Fax: ___________

Gestational Age: _____ Weeks ____ Days Current Weight: ______(kg) Dose: _______ 15mg/kg (verified monthly)

Diagnosis (please submit supporting clinical documentation):

☐ Infants born at 28 weeks of gestation or earlier (i.e., ≤ 28 weeks, 6 days) and under 12 months of age at the start of the RSV season (maximum 5 doses)

☐ Infants born at 29-32 weeks (i.e., between 29 weeks, 0 days and 31 weeks, 6 days) of gestation and under 1 year of age at the start of the RSV season who develop chronic lung disease of prematurity defined as a requirement for >21% oxygen for at least the first 28 days after birth (maximum 5 doses)

☐ Children under 24 months of age who will undergo a heart transplant during the RSV season (maximum 5 doses)

☐ Children under 24 months of age who are profoundly immunocompromised during the RSV season (e.g. undergoing organ or hematopoietic stem cell transplant or receiving chemotherapy) (maximum 5 doses)

☐ Children under 24 months of age with chronic lung disease of prematurity defined as born at 31 weeks, 6 days or less who required >21% oxygen for at least the first 28 days after birth and continue to require medical support (chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) during the 6- month period before the start of the second RSV season (maximum 5 doses).
Treatment: ____Dates of Use: ___________

☐ Children under 12 months of age with hemodynamically significant congenital heart disease (CHD) (dosing continues in the RSV season through the end of the month the infant reaches 12 months old -maximum 5 doses)
- ☐ Acyanotic heart disease and receiving medication to control congestive heart failure and will require cardiac surgical procedure
- ☐ Moderate to severe pulmonary hypertension
- ☐ Cyanotic heart disease and recommended for Synagis therapy by Pediatric Cardiologist

☐ Infants under 12 months of age with either: (dosing continues in the RSV season through the end of the month the infant reaches 12 months old – maximum 5 doses)
- ☐ Congenital abnormalities of the airways that impairs the ability to clear secretions from the upper airway because of ineffective cough
- ☐ Neuromuscular condition that impairs the ability to clear secretions from the upper airway because of ineffective cough

☐ Other: ____

CHANGE HEALTHCARE

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NICU HISTORY

Did the patient spend time in the NICU?

☐ Yes ☐ No (If yes, please attach the NICU summary)

Was RSV prophylaxis recommended by the NICU/Hospital physician for this patient?

☐ Yes ☐ No

Was a NICU/Hospital /Clinic dose administered?

☐ Yes, Date(s): __________

PRESCRIPTION

Synagis (palivizumab) 50 and/or 100 mg vials and supplies for administration.

Sig: Inject 15 mg/kg IM once every 4 weeks; expected date of first home injection: ____
Dispense Quantity: Quantity sufficient for prophylaxis thru 04/2019

Deliver product to: ☐ MD office ☐ Patient's home ☐ Clinic

☐ Home health nurse to administer injection Home Health Agency: ____
If delivery is to clinic, please give location:

Pediatric Anaphylaxis: Administer 0.01 ml/kg (max 0.3ml) of 1:1000 epinephrine solution subcutaneously or intramuscularly, and contact EMS as appropriate.

Other:____
Sig: ____

Physician will monitor patient's response to therapy. Any complications in therapy will be reported to the physician either by the patient's caregiver or the skilled nursing service. Requests for dose changes resulting from weight gain must be submitted to Change Healthcare via fax: 844-679-5366.

Prescriber's Signature:____**Date:** ___________

Supervising Physician's Signature:____ Date: ___________

This order is valid for the entire upcoming season if signed prior to the December dose, or for the remainder of the present season if signed after December.