

## Synagis® Prior Authorization

Submit fax request to: 855-455-3303

**Purpose:** For a prescribing physician to request Synagis® for the Nevada Respiratory Syncytial Virus (RSV) season November 1, 2012, through April 1, 2013. Synagis® authorization will not be issued for therapy dates in the 2012 season after April 1, 2013.

**Questions:** If you have any questions, please call the SXC Clinical Pharmacy Services Call Center at 855-455-3311.

<b>DATE OF REQUEST:</b>		
<b>RECIPIENT INFORMATION</b>		
Last name, First name, Middle initial:		Date of birth:
Recipient ID:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone:
Dx: _____	Gestational age: _____ Weeks _____ Days <b>*Both weeks and days are required.</b>	
Current weight: _____	Date on which current weight was recorded:	
<b>PROVIDER INFORMATION</b> (This request <u>must</u> be submitted by the prescribing physician.)		
Name:		NPI:
Specialty:	Phone:	Fax (required):
Person to contact regarding this request:		
<b>COVERAGE CRITERIA</b>		
<b>Please check the applicable boxes to indicate each item as true for the recipient:</b>		
<input type="checkbox"/> Child is < 24 months of age at the onset of RSV season on November 1 (born after 11/1/10).		
<input type="checkbox"/> Child has a diagnosis of chronic lung disease of prematurity (formerly called bronchopulmonary dysplasia).		
<input type="checkbox"/> Child has required medical treatment in the preceding six months.		
Please check all that apply and document administration dates:		
<input type="checkbox"/> Oxygen	Most recent date administered: _____	
<input type="checkbox"/> Corticosteroids	Most recent date administered: _____	
<input type="checkbox"/> Bronchodilators	Most recent date administered: _____	
<input type="checkbox"/> Diuretics	Most recent date administered: _____	
<input type="checkbox"/> Child has hemodynamically significant cyanotic or acyanotic congenital heart disease (CHD)		
Please check all that apply and document medications received or date of surgeries:		
<input type="checkbox"/> Congestive heart failure or cardiomyopathy;	Medications: _____	
<input type="checkbox"/> Moderate to severe pulmonary hypertension;	Medications: _____	
<input type="checkbox"/> Cyanotic heart disease;	Medications: _____	
<input type="checkbox"/> Cardiopulmonary bypass surgery;	Date: _____	
<input type="checkbox"/> Child is ≤ 12 months of age at the onset of RSV season on November 1 (born after 11/1/11)		
Please check all that apply:		
<input type="checkbox"/> Born at gestational age ≤ 28 weeks		
<input type="checkbox"/> Born at gestational age ≤ 34 weeks, 6 days		
<input type="checkbox"/> The child has congenital abnormalities of the airway.		
<input type="checkbox"/> The child has a neuromuscular condition requiring handling of respiratory secretions.		
<input type="checkbox"/> Child is ≤ 6 months of age at the onset of RSV season on November 1 (born after 5/1/12)		
<input type="checkbox"/> Born at gestational age 29 weeks, 0 days through 31 weeks, 6 days.		
<input type="checkbox"/> Child is ≤ 3 months of age at the onset of RSV season on November 1 (born after 8/1/12)		
Please check all that apply (children in this category qualify for monthly doses only up until three months of age):		
<input type="checkbox"/> Born at gestational age 32 weeks, 0 days through 34 weeks, 6 days		
<input type="checkbox"/> The child attends daycare (a home or facility where care is provided for any number of infants or young toddlers).		
<input type="checkbox"/> The child resides in a home with another child < 5 years of age.		
<b>PROVIDER CERTIFICATION</b> – Prescriber's signature and date is required.		
<b>I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Nevada Medicaid.</b>		
Prescriber's Signature: _____		Date: _____

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.