

OHIO DEPARTMENT OF MEDICAID

PRIOR AUTHORIZATION SYNAGIS (palivizumab)*(Criteria Based on 2014 American Academy of Pediatrics Red Book Guidelines)******Supporting Documentation is REQUIRED for Synagis Request*****

Request Date		Review Type Requested <input checked="" type="checkbox"/> Standard <input type="checkbox"/> Urgent
Individual's Medicaid ID Number		Prescriber's Full Name
Individual's Name		Prescriber's NPI Number
<input type="checkbox"/> Male <input type="checkbox"/> Female	Gestational Age at Birth: Weeks Days	Prescriber's Phone Number
Individual's Date of Birth	Current Weight (kg)	Prescriber's Fax Number
(If Known) Pharmacy's Name		Pharmacy's Phone Number

DIAGNOSIS AND INDIVIDUAL HISTORY (CHECK ALL THAT APPLY)

Diagnosis and ICD-10 (REQUIRED)	
<input type="checkbox"/> Prematurity (<i>gestational age 28 weeks, 6 days or less</i>) <input type="checkbox"/> Chronic lung disease of prematurity during 1st year of life (<i>< 12 months of age</i>) ICD-10 code required <i><32 weeks GA requiring >21% of oxygen for at least the first 28 days after birth.</i> <input type="checkbox"/> Chronic lung disease of prematurity during 2nd year of life (<i>< 24 months of age</i>) ICD-10 code required <i><32 weeks GA requiring >21% of oxygen for at least the first 28 days after birth and continued medical support (e.g. chronic corticosteroid, bronchodilator, or diuretic therapy; supplemental oxygen) during 6-month period before start of second RSV season</i>	
<input type="checkbox"/> Hemodynamically significant CHD during 1st year of life (< 12 months of age)	
Diagnosis of hemodynamically significant acyanotic CHD? <input type="checkbox"/> Yes <input type="checkbox"/> No	Diagnosis of hemodynamically significant cyanotic CHD? <input type="checkbox"/> Yes <input type="checkbox"/> No
Consultation with a pediatric cardiologist regarding palivizumab? <input type="checkbox"/> Yes <input type="checkbox"/> No	Diagnosis of moderate-to-severe pulmonary HTN? <input type="checkbox"/> Yes <input type="checkbox"/> No
Severe neuromuscular disease (< 12 months of age)	
<input type="checkbox"/> Congenital abnormalities of airways (< 12 months of age) <input type="checkbox"/> Profoundly Immunocompromised (\leq 24 months of age) <input type="checkbox"/> Has received cardiac transplantation (< 24 months of age) Date: _____ <input type="checkbox"/> Other	

TREATMENT HISTORY (CHECK ALL THAT APPLY)

List of medications used to control CHF or pulmonary HTN:

<input type="checkbox"/> Oxygen (dates/duration)	<input type="checkbox"/> Bronchodilators (dates/duration)
<input type="checkbox"/> Steroids (dates/duration)	<input type="checkbox"/> Diuretics (dates/duration)

Rx info: Synagis (palivizumab) 50mg and/or 100mg vials Directions: Inject 15mg/kg IM one time per month

Number of Doses	Date of first injection	Quantity	Refills
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☐ I attest that I am a member of the prescriber's staff in accordance with Ohio Administrative Code rule 5160-9-03, as applicable. Only the prescribing provider or a member of the prescribing provider's staff may request prior authorization.

Prescriber's Signature (or staff of prescriber)_____
Date_____
IF a staff member is attesting, please print your name

Fax To: OHIO Department of Medicaid
Fax: (800) 396-4111 PA Helpdesk: (877) 518-1546
Hours: Monday-Friday 8:00 am – 8:00 pm EST