

<h1 style="margin:0;">OHIO MEDICAID</h1> <h2 style="margin:0;">SYNAGIS®</h2> (palivizumab)	SYNAGIS Prior Authorization Worksheet/Prescription Order Form. Please FAX this completed form to 800-396-4111	SUPPORTING DOCUMENTATION IS REQUIRED FOR SYNAGIS REQUEST (CHART NOTES, LAB RESULTS, ETC.)
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PATIENT INFORMATION

Patient's (Child's) Name: _____ M F Patient Medicaid # _____

DOB _____ Age as of Nov 1st _____ Gestational Age (GA) _____ Weeks _____ Days _____

Birth Weight _____ lb/kg Current Weight _____ lb/kg Date: _____

Prescriber Name _____ Prescriber Fax # _____

Synagis Criteria Based on 2014 American Academy of Pediatrics Red Book Guidelines
MEDICAL AUTHORIZATION CLINICAL CRITERIA (Please check ALL that apply.)

_____ ICD-10-CM (Supporting documentation is REQUIRED for Synagis request)	Chronic Lung Disease of Prematurity during 1st year of life (≤ 12 months of age) < 32 weeks GA > 21% oxygen requirement for at least first 28 days after birth
	Chronic Lung Disease of Prematurity during 2nd year of life (< 24 months of age) < 32 weeks GA requiring > 21% of oxygen for at least the first 28 days after birth. Requirement for continued medical support (e.g., chronic corticosteroid, bronchodilator, or diuretic therapy; supplemental oxygen) during 6-month period before start of second RSV season
	Treatment:
	Supplemental oxygen: yes / no Days/Duration
	Steroids: yes / no Days/Duration
Bronchodilators: yes / no Days/Duration	
Diuretics: yes / no Days/Duration	
_____ ICD-10-CM	Hemodynamically Significant CHD during 1st year of life (≤ 12 months of age) with moderate to severe pulmonary hypertension ICD-10-CM _____ who are receiving medication to control congestive heart failure - ICD-10-CM _____ List medications: Other _____ Dx ICD-10-CM _____
	(Supporting documentation is REQUIRED for Synagis request)

Diagnosis for Consideration (Please Check ALL that apply.) (Supporting documentation is REQUIRED for Synagis request)

Infants born before 29 weeks GA (28 weeks, 6 days or less)

Severe Neuromuscular Disease (≤ 12 months of age) Congenital Abnormalities of Airways (≤ 12 months of age)

Immunosuppressive/autoimmune disease (≤ 24 months of age);
 Diagnosis _____

Receiving chemotherapy yes / no

Undergoing cardiac transplantation (≤ 24 months of age) Date _____ Other _____

PRESCRIPTION INFORMATION

Synagis® (palivizumab) 50 mg and/or 100 mg vials Sig: Inject 15 mg/kg IM one time per month _____ # Doses

Date for first Injection: _____ Delivery to: Patient's Home MD Office

Prescriber's Signature: _____ Prescriber's NPI _____ Date: _____