



West Virginia Medicaid
Drug Prior Authorization Form

<http://www.dhhr.wv.gov/bms/Pharmacy/Pages/default.aspx>

Synagis® Prior Authorization Form
(palivizumab)

Rational Drug Therapy Program
WVU School of Pharmacy
PO Box 9511 HSCN
Morgantown, WV 26506
Fax: 1-800-531-7787
Phone: 1-800-847-3859

Patient Name (Last)	(First)	(M)	WV Medicaid 11 Digit ID#	Date of Birth (MM/DD/YYYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Prescriber Name (Last)	(First)	(MI)
<input type="text"/>	<input type="text"/>	<input type="text"/>

Prescriber Address (Street)	(City)	(State)	(Zip)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Prescriber 10-Digit NPI#	Phone # (111-222-3333)	Fax # (111-222-3333)
<input type="text"/>	<input type="text"/>	<input type="text"/>

Pharmacy Name (if applicable)
<input type="text"/>

Pharmacy Address (Street)	(City)	(State)	(Zip)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Pharmacy 10-Digit NPI#	Phone # (111-222-3333)	Fax # (111-222-3333)
<input type="text"/>	<input type="text"/>	<input type="text"/>

Confidentiality Notice: This document contains confidential health information that is protected by law. This information is intended only for the use of the individual or entity named above. The intended recipient of this information should destroy the information after the purpose of its transmission has been accomplished or is responsible for protecting the information from any further disclosure. The intended recipient is prohibited from disclosing this information to any other party unless required to do so by law. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately by telephone at (800) 847-3859 and arrange for the return or destruction of these documents. Thank you.

Important Notes: Preauthorization for medical necessity does not guarantee payment.
The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

Please check applicable indication. Supporting documentation is required for all indications.

Infant / Child Age at Start of RSV Season	Criteria
≤ 12 months (1st year of life)	<input type="checkbox"/> Gestational Age (GA) <29 weeks, 0 days and otherwise healthy <input type="checkbox"/> Chronic Lung Disease (CLD) of prematurity (GA <32 wks, 0 days requiring >21% supplemental O ₂ x first 28 days after birth.) <input type="checkbox"/> Anatomic pulmonary abnormalities, or neuromuscular disorder, or congenital anomaly that impairs the ability to clear secretions. <input type="checkbox"/> Profoundly immunocompromised <input type="checkbox"/> Cystic Fibrosis (CF) with CLD and/or nutritional compromise <input type="checkbox"/> Congestive Heart Failure (CHF) (hemodynamically <i>significant</i>) with <i>acyanotic</i> Heart Disease (HD) on CHF medications and who will require cardiac surgery or who have moderate to severe Pulmonary Hypertension (PH). For <i>cyanotic</i> heart defects, consult a pediatric cardiologist.
> 12 months to ≤ 24 months (2nd year of life)	<input type="checkbox"/> CLD of prematurity (GA <32 wks, 0 days requiring >21% supplemental O ₂ x first 28 days after birth) and medical support (chronic systemic steroids, diuretic therapy, or supplemental O ₂) within 6 months before start of 2nd RSV season. <input type="checkbox"/> CF with severe lung disease or weight for length <10th percentile <input type="checkbox"/> Cardiac transplant during RSV season <input type="checkbox"/> Already on prophylaxis and eligible: give post-op dose after cardiac bypass or after ECMO <input type="checkbox"/> Profoundly immunocompromised.

Drug Name: palivizumab - (Synagis®)	Dose	Current Weight (in kg)	ICD Diagnosis Code (if available)
	<input type="text"/>	<input type="text"/>	<input type="text"/>

Were any doses previously administered to the patient for the current RSV season (November 1st)? Yes No Date Administered:

Gestational Age Weeks Days Chronological Age

Is the patient currently in the hospital? Yes No

Has the patient been in the hospital since the start of the current RSV Season (November 1st)? Yes No

If yes, were any doses of Synagis® administered while patient was hospitalized? Yes No If yes, please provide date:

Medical justification / Reference attached supporting documentation (attach additional pages if necessary)

Medications (include medication name, start date and end date for diagnoses that require acceptable medical therapy (attach additional pages if necessary)

Other Pertinent Information (attach additional pages if necessary)

Attestation: Your signature (manually or electronically) certifies that the above request is medically necessary, does not exceed the medical needs of the member, and is documented in your medical records. Medical/Pharmacy records must be made available upon request.

Check here for electronic signature

Prescriber or Pharmacist Signature

Date:
(MM/DD/YYYY)