TennCare

Prior Authorization Form

Synagis®

Access this PA form at https://tenncare.magellanhealth.com/static/docs/Prior_Authorization_Forms/Synagis_PA_Request_Form.pdf

If the following information is not complete, correct, or legible, the PA process can be delayed. Use one form per member please.

Member Information

LAST NAME: **FIRST NAME:**

ID NUMBER: **DATE OF BIRTH:** – –

Prescriber Information

LAST NAME: **FIRST NAME:**

NPI NUMBER: **DEA NUMBER:**

PHONE NUMBER: – – **FAX NUMBER:** – –

****Synagis® approvals may begin therapy **November 1st** with last date of therapy not to exceed **April 30th** (end of RSV season)****

STRENGTH: ☐ 50 mg ☐ 100 mg **DIRECTIONS:** ______________ **PATIENT WEIGHT:** ______________

NAME OF DISPENSING PHARMACY: ______________ **NPI NUMBER:** ______________

Clinical Criteria Documentation *****Do **not** include documentation that is not requested on this form*****

1. **What is the patient's gestational age?** ________________weeks ______________days
2. **Does the patient have Chronic Lung Disease of Prematurity (Formerly called brochopulmonary dysplasia)** ☐ Yes (go to 2a) ☐ No (go to 3)
   a. **Did the patient receive Oxygen immediately following birth?** ☐ Yes (go to 2b) ☐ No (go to question 3)
   b. **Please indicate the % oxygen received :** _________ **Duration of treatment:** ______________
   c. **Please indicate if patient is receiving any of the following respiratory support therapies on a daily basis:**
      ☐ Oxygen Most recent date administered: ______________
      ☐ Systemic corticosteroids Most recent date administered: ______________
      ☐ Diuretics Most recent date administered: ______________
3. **Does the patient have a diagnosis of Cystic Fibrosis?** ☐ Yes (go to question 3a) ☐ No (go to question 4)
   a. **Has the patient been hospitalized for a pulmonary exacerbation?** ☐ Yes (Date: ______________) ☐ No
   b. **Does the patient have pulmonary abnormalities on chest x-ray or CT that persist when the patient is stable?** ☐ Yes ☐ No
   c. **What is the patient's weight for length percentile?** ______________
4. **Please indicate if patient has any of the following:**

☐ Anatomic Pulmonary Abnormality, specify: ______________ ☐ Neuromuscular Disorder, specify: ______________

☐ Congenital anomaly that impairs the ability to clear secretions, specify: ______________

5. **Please indicate if patient has any of the following:**

☐HIV ☐ Cancer, receiving chemotherapy ☐Organ transplant receiving immunosuppressant therapy

☐ Other medical condition severely immunocompromising patient, specify: ______________

6. **Has this patient received a heart transplant?** ☐ Yes (Date: ______________) ☐ No
7. **Does patient have hemodynamically significant congenital heart** ☐ Yes (please indicate) ☐ No

☐ Acyanotic heart disease (specify: ______________)

☐ Cyanotic heart disease (specify: ______________; Name of Pediatric Cardiologist:______________)

☐ Pulmonary Hypertension ☐ Other: ______________

8. **Will this patient's congenital heart disease require cardiac surgery?** ☐ Yes ☐ No

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TennCare Pharmacy Program, c/o Magellan Health Services, 1st Floor South, 14100 Magellan Plaza, Maryland Heights, MO 63043.
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9. Please list any medications that may be used:

- ☐ Ace-Inhibitor/ARB Most recent date administered: ____________________
- ☐ Diuretic Most recent date administered: ____________________
- ☐ Beta-blocker Most recent date administered: ____________________
- ☐ Digoxin Most recent date administered: ____________________
- ☐ Other cardiovascular medications (specify): ____________________

10. If this is a request for a sixth dose of Synagis during the RSV season, has the patient had an ECMO or cardiac bypass during the RSV season?

☐ Yes (Date: ____________________ ☐ No

Please note any other information pertinent to this PA request:

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____________________ ____________________

Prescriber Signature (Required) ***Date***

(By signature, the Physician confirms the above information is accurate and verifiable by patient records.)

Fax This Form to: 1-866-434-5523

Mail requests to: TennCare Pharmacy Program
c/o Magellan Health Services
1st floor South, 14100 Magellan Plaza
Maryland Heights, MO 63043
Phone: 1-866-434-5524

Magellan Health Services will provide a response within 24 hours upon receipt.

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