

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 bronchopulmonary 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:

<input type="checkbox"/> Oxygen	Most recent date administered: _____
<input type="checkbox"/> Systemic corticosteroids	Most recent date administered: _____
<input type="checkbox"/> 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:

<input type="checkbox"/> Anatomic Pulmonary Abnormality, specify: _____	<input type="checkbox"/> Neuromuscular Disorder, specify: _____
<input type="checkbox"/> Congenital anomaly that impairs the ability to clear secretions, specify: _____	
5. Please indicate if patient has any of the following:

<input type="checkbox"/> HIV	<input type="checkbox"/> Cancer, receiving chemotherapy	<input type="checkbox"/> Organ transplant receiving immunosuppressant therapy
<input type="checkbox"/> 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

<input type="checkbox"/> Acyanotic heart disease (specify: _____)
<input type="checkbox"/> Cyanotic heart disease (specify: _____; Name of Pediatric Cardiologist: _____)
<input type="checkbox"/> Pulmonary Hypertension <input type="checkbox"/> Other: _____
8. Will this patient's congenital heart disease require cardiac surgery? Yes No



Prior Authorization Form
Synagis®

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9. Please list any medications that may be used:

- Medication categories: Ace-Inhibitor/ARB, Diuretic, Beta-blocker, Digoxin, Other cardiovascular medications (specify). Includes fields for 'Most recent date administered'.

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/No checkboxes with date field for Yes.

Please note any other information pertinent to this PA request:

Multiple horizontal lines for providing additional information.

Prescriber Signature (Required)

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

Date

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.

