

OHIO MEDICAID**SYNAGIS®**
(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.)****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.)

<input type="checkbox"/> 770.7 (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
<input type="checkbox"/> 745-747 (Supporting documentation is REQUIRED for Synagis request)	Hemodynamically Significant CHD during 1st year of life (≤ 12 months of age)		
	with moderate to severe pulmonary hypertension -747.83 or _____ who are receiving medication to control congestive heart failure -779.89 _____		
List medications: _____			
Other _____ Dx ICD-9 _____			

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