FAX completed form to
Change Healthcare
1-866-964-3472

MULTIPLE USE**
PRIOR AUTHORIZATION REQUEST FORM

PHONE:
(For questions or inquiries ONLY)
1-877-207-1126

SYNAGIS®

Provider must fill in all information below. It must be legible, correct and complete or the form will be returned.

Client ID #: |____|____|____|____|____|____|____|____|____|____|

Client's Full Name:_____ DOB: _____

Prescriber NPI: |____|____|____|____|____|____|____|____|____|____|

Prescriber's Full Name:_____ Phone: _____

Prescriber Address: _____ Fax:_____

Pharmacy NPI: |____|____|____|____|____|____|____|____|____|____|

Pharmacy Name: _____ Phone: _____

Wyoming Medicaid will approve Synagis® PA requests for clients that meet the guidelines below. Requests will only be approved for a maximum of 5 doses at a dosing interval of not less than 28 days between injections. If the client has tested positive for RSV, further requests for Synagis will not be approved. Claims submitted for a day supply less than 28 days may be subject to recovery.

CLIENT'S GESTATIONAL AGE: _____

MEDICAL NECESSITY DOCUMENTATION *(Please check all that apply):*

□ **CHRONIC LUNG DISEASE:** Client is **≤ 24 months** of age at start of therapy and has chronic lung disease of prematurity (i.e. bronchopulmonary dysplasia), continues to require medical intervention (chronic corticosteroid or diuretic therapy) or required supplemental oxygen for at least 28 days after birth.

□ **CONGENITAL HEART DISEASE:** Client **is ≤12 months** of age at start of therapy and has hemodynamically significant congenital heart disease and one or more of the following: (please check all that apply)
- □ Is receiving medication to control congestive heart failure
- □ Has a diagnosis of moderate to severe pulmonary hypertension
- □ Has a diagnosis of cyanotic heart disease

□ **PREMATURITY:**
- □Client is ≤12 months of age at start of RSV season and born at **≤28 weeks, 6 days** gestational age.
- □Client is ≤12 months of age at start of RSV season and born at **34 weeks, 6 days or less** gestational age and has either severe neuromuscular disease or congenital abnormalities, either of which compromise handling of respiratory secretions.
- □Client is ≤ 6 months of age at start of RSV season and born between **29 weeks, 0 days** and **35 weeks, 6 days** gestational age.

□ **OTHER (Please include any applicable information including gestational age if client was born premature and does not meet the above criteria):**

_____

Please indicate if the client has received Synagis® in an inpatient setting. If yes, provide the date(s) of administration and dose:
□ *No* □ *Yes* ***Administration Date(s):*** _____ ***Dose:*** _____

****Please submit (by fax) the same PA form per client per season****

SYNAGIS®	ANTICIPATED ADMINISTRATION DATE	PREVIOUS DOSE ADMINISTRATION DATE	CLIENT'S WEIGHT	POSITIVE RSV TEST IN 2023-2024?	HAS CLIENT RECEIVED BEYFORTUS?	PRESCRIBER'S INITIALS
1st Dose			Lbs oz			
2nd Dose			Lbs oz			
3rd Dose			Lbs oz			
4th Dose			Lbs oz			
5th Dose			Lbs oz			

Prescriber Signature: _____ **Date(s) of Submission:** _____ _____ _____ _____ _____

1ST DOSE *2ND* *3RD* *4TH* *5TH*

** Prescriber's original signature required; copied, stamped, or e-signatures are not allowed. By signature, the prescriber confirms the criteria information above is accurate and verifiable in client records.*

American Academy of Pediatrics-Website: http://aapredbook.aappublications.org/cgi/content/full/2009/1/3.110