MHS PHARMACY BENEFIT
SYNAGIS PRIOR AUTHORIZATION REQUEST FORM

MHS
550 N. Meridian St. Suite 101
Indianapolis, IN, 46204-1208
Phone: (877) 647-4848 Fax: (866) 399-0929

Today's Date
☐☐ / ☐☐ / ☐☐☐☐

Note: This form must be completed by the prescribing provider.

****All sections must be completed or the request will be returned****

Patient's Medicaid # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Prescriber's Signature
Return Fax # ☐☐☐ - ☐☐☐ - ☐☐☐☐	Return Phone # ☐☐☐ - ☐☐☐ - ☐☐☐☐
Check box if requesting retroactive PA ☐	Date(s) of service requested for retroactive eligibility (if applicable):

Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).

1. Patient Information:
Actual Gestational Age: _____weeks _____days **Current Age (Must be < 24 months):** _____ months

Current Weight: _____ ☐ kg ☐ lb

2. Prescription Information: ☐ **Inject 15mg/kg IM once per month through March 31st**

☐ **Other:** _____

3. Palivizumab Prior Approval Criteria Guidelines for a maximum of 5 doses (approval will be granted under any of the following circumstances):

☐ Infants < 12 months of age born preterm before 32 weeks gestation

☐ Infants < 12 months of age born with chronic lung disease (CLD) or bronchopulmonary dysplasia (BPD) (defined as: an oxygen requirement for at least 28 days after birth or those that developed an oxygen requirement)

Please provide dates of oxygen supplementation:

_____

☐ Infants < 12 months of age and requiring medical therapy for hemodynamically significant heart disease or cardiomyopathies

Please provide relevant diagnoses/medication intervention:

_____

☐ Infants < 12 months of age with neuromuscular disease or congenital abnormalities of the airways

Please provide relevant diagnoses:_____

☐ Infants and children < 24 months of age who required at least 28 days of supplemental oxygen after birth, and continue to require medical intervention (supplemental oxygen, chronic corticosteroid use, diuretic therapy)

Please provide dates of oxygen supplementation/medication intervention:

_____

☐ Infants and children < 24 months of age who will be profoundly immunocompromised during the RSV season (solid organ or hematopoietic stem cell transplant, chemotherapy, or other condition that leaves the infant or child profoundly immunocompromised, including those awaiting heart transplant)

Please explain:

_____

☐ Infants and children < 24 months of age with evidence of hemodynamically significant coronary heart disease, cardiomyopathies, or pulmonary hypertension

Please explain:

_____

Note: *Prophylaxis will be given only until the infant or child reaches a maximum of 5 doses or the end of the RSV season, whichever comes first.*

The Respiratory Syncytial Virus (RSV) season is defined as November 1 through March 31. The Office of Medicaid Policy & Planning may extend the season based on statewide virology data. Administration of additional doses will require separate prior authorization. Please note that the criterion presented on the form pertains to the IHCP pharmacy benefit only.

CONFIDENTIAL INFORMATION

This facsimile transmission (and attachments) may contain protected health information from MHS, which is intended only for the use of the individual or entity named in this transmission sheet. Any unintended recipient is hereby notified that the information is privileged and confidential, and any use, disclosure, or reproduction of this information is prohibited.