CLEAR HEALTH ALLIANCE

Prior Authorization

SYNAGIS® - All Florida Regions

Coverage Period: July 1st through April 30th
Maximum number of doses: 7
(No authorizations for May and June)

Member Medicaid ID#

Date of Birth (MM/DD/YYYY) ___ ___ / ___ ___ / ___ ___ ___ ___

Member Full Name

Prescriber's Full Name

Prescriber's License # (ME, OS, RN)

Prescriber Phone Number ___ ___ ___ - ___ ___ ___ ___

Prescriber Fax Number ___ ___ ___ - ___ ___ ___ ___

SYNAGIS VIAL QTY:
SIG: Inject 15 mg/kg IM once monthly

☐ 100 mg ☐ 50 mg

Start Date: _____ Refill(s): _____ mos

Birth Weight: _____ Current Weight: _____

Gestational Age: _____

☐ If < or = 24 months old

☐ Cystic Fibrosis ☐ Down's Syndrome

☐ Hemodynamically significant cyanotic and acyanotic congenital heart disease: (Specify ICD-9 Code) _____

☐ Chronic lung disease*: (Specify ICD-9 Code) _____

AND: requiredanyofthefollowingtherapieswithinthepast6months:

☐ Supplemental oxygen ☐ Steroids (systemic or inhaled) ☐ Digitalis
☐ Mechanical ventilation ☐ Diuretics ☐ Bronchodilator

*CLD is not asthma, croup, recurrent upper respiratory infections, chronic bronchitis, chronic bronchiolitis, or a history of a previous RSV infection.

☐ If < 12 months old (no CLD, no CHD)

☐ < or = 28 Completed weeks gestational age at birth: ICD-9 Code: 765.21–765.24

☐ If < 6 months old (no CLD, no CHD)

☐ > 28 to < 32 Completed weeks gestational age: ICD-9 Code: 765.25–765.26
OR
☐ 32 to 35 Completed weeks gestational age: ICD-9 Code: 765.26–765.28

WITH: atleastoneofthefollowingriskfactors:

☐ Severe neuromuscular disease (Specify ICD-9 code)
☐ Congenital anomalies of the airways (Specify ICD-9 code)
☐ Attends child care
☐ Direct contact with siblings who attend school or child care

Prescriber's Signature _____ DATE: _____

Please attach a copy of the original prescription.
The provider must retain copies of all documentation for five years.

Fax Information to:
Clear Health Alliance
Tel: (877) 577-9044
Fax: (877) 577-9045

For CLEAR HEALTH PHARMACY Use Only

DATE: _____ **NOTIFIED:** _____
APPROVED: _____ **START DATE:** _____ **EXPIRATION DATE:** _____
DENIAL OVERRIDE: _____ **REASON:** _____

CLEAR HEALTH ALLIANCE

SERVICES PROTOCOL

Synagis® (palivizumab)

Clinical Criteria for Synagis®(palivizumab):

Synagis® may be approved for patients under the age of 2 years meeting the following criteria:

- If the patient has a diagnosis of Down Syndrome or Cystic Fibrosis.
- For patients less than 6 months of age as of July 1, request may be approved for **ONE** of the following:
  - If the patient was born at 32 weeks (32 weeks, 0 days) gestation or earlier
  - If the patient was born between 32-35 weeks gestation (between 32 weeks, 1 day and 35 weeks, 0 days), the patient must have one or more of the following risk factors for severe RSV disease:
    - Child care out of the home
    - Siblings attending school or day-care
    - Congenital abnormalities of the airways (with ICD-9 codes)
    - Severe neuromuscular disease (with ICD-9 codes)
  - If the patient has a Chronic Lung Disease [bronchopulmonary dysplasia (BPD)] that has required daily respiratory medications or treatments within the previous 6 months.
  - If the patient has a diagnosis of hemodynamically significant congenital heart disease* (which often includes those receiving medication to control CHF, those with moderate to severe pulmonary hypertension, or those with cyanotic heart disease)
- For patients 6 months to less than 12 months of age as of July 1, request may be approved for **ONE** of the following:
  - If the patient was born at 28 weeks gestation or earlier
  - If the patient has a Chronic Lung Disease [bronchopulmonary dysplasia (BPD)] that has required daily respiratory medications or treatments within the previous 6 months.
  - If the patient has a diagnosis of hemodynamically significant congenital heart disease* (which often includes those receiving medication to control CHF, those with moderate to severe pulmonary hypertension, or those with cyanotic heart disease)
- For patients 12 months to less than 24 months of age as of July 1, request may be approved for **ONE** of the following: **(Approval length up to the last day of their birth month or April 30th, whichever occurs first)**
  - If the patient has a Chronic Lung Disease [bronchopulmonary dysplasia (BPD)] that has required daily respiratory medications or treatments within the previous 6 months.
  - If the patient has a diagnosis of hemodynamically significant congenital heart disease* (which often includes those receiving medication to control CHF, those with moderate to severe pulmonary hypertension, or those with cyanotic heart disease)

***NOTE**: Synagis will not be approved for those infants and children with hemodynamically insignificant heart disease.

NOTE: Pharmacies should not submit separate claims for different dosage strength vials to be administered on the same date. Only one compound claim submission will be necessary. For example, if the Synagis dosage is 150 mg the pharmacy should submit a compound claim that lists the two different strength vials (100mg and 50mg).

Weight Criteria for Synagis®(palivizumab): (Refer to Weight Change Form)

- All weights must be verified for dosing accuracy.

Reference: Florida Medicaid Synagis Prior Authorization Form.

CLEAR
HEALTH ALLIANCE

Prior Authorization

Synagis®

Weight Change Form

- **Any dosage increase must have corresponding weight charts and/or progress notes with current weight.**
- **If the dose needed is less than 5 mg over the approved vial size, round down to the nearest vial size. If the dose needed is ≥ 5 mg over the approved vial size, then the new vial size will be approved. For those patients who are expected to gain enough weight to need an additional vial, please schedule a visit to obtain weight & receive approval for dose increase prior to the Synagis® administration date. There are no immediate approvals for "waiting" patients.**
- **In cases where immediate administration of medication is required, providers should use the currently authorized vial size(s), then submit a weight change request, which will be applied to subsequent dosages only.**

Beneficiary's Medicaid ID#

Date of Birth (MM/DD/YYYY) ___ / ___ / ____

Beneficiary's Full Name

Prescriber's Full Name

Prescriber License # (ME, OS, RN)

Prescriber Phone Number ___ - ___

Prescriber Fax Number ___ - ___

Pharmacy Name

Pharmacy Medicaid Provider #

Pharmacy Phone Number ___ - ___

Pharmacy Fax Number ___ - ___

1. Previous Weight: _____
2. Current Weight: _____
3. New Dose Required: _____

Prescriber's Signature: _____ DATE: _____

This documentation must be dated and signed by the requesting practitioner.

The provider must retain copies of all documentation for five years.

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DATE: _____ NOTIFIED: _____

APPROVED: _____ START DATE: _____ EXPIRATION DATE: _____

DENIAL OVERRIDE: _____ REASON: _____