

FLORIDA MEDICAID

Prior Authorization

SYNAGIS® – All Florida Regions Combined

	Coverage Period: Based upon the specific region per the FLDOH website: http://www.floridahealth.gov/diseases-and-conditions/respiratory-syncytial-virus/																												
											Maximum number of doses: 5																		
Note: Form must be completed in full. An incomplete form may be returned												met																	
Recipient's Medicaid ID#										Date	Date of Birth (MM/DD/YYYY)																		
																	/												
Rec	ipien	ťs F	ull Na	ame		[1				[1		1	<u> </u>			
Pre	scrib	er's F	- ull N	lame	e	-		-				-	_				-		-	-	-		_	-	_				
Pre	scrib	er's N	NPI															I								<u> </u>			
Pre	escriber Phone Number										Prescriber Fax Number																		
			_				-														-				-				
]																						
	nagis G: Inied			ı IM d	once	moni	thlv		Star	t Dat	e:									R	efill(s	s):			m	os			
											s/□	kas																	
100 mg 50 mg Gestational Age (GA) :										_	_	U																	
												.9- (,																
	f < 24	4 mor	nths c	old																									
	Cardia	ac trai	nspla	nt dı	uring	RSV	′ sea	son																					
	Alread	ly on	proph	nylax	kis ar	nd eli	gible	; giv	e pos	st-op	dose	e afte	er ca	rdiac	bypa	iss or	aftei	r ECI	МО										
	Profou	-		-			-			-																			
		,			·				,	•	,	U		,															
	f > 12	mon	ths o	ld ar	nd < 2	24 m	onth	s old																					
	Cyst	ic Fib	rosis																										
	AND	: mus	st me	et at	t leas	st one	e of th	ne fo	llowi	ng cr	iteria	l																	
		Nutrit	ional	com	npron	nise	(weig	ht fo	or len	gth <	10 th	perc	centil	e)															
		Hosp	italiza	ation	for p	oulmo	onary	exa	cerba	ation	in fir	st ye	ear o	f life															
		Ches	t X-ra	iy or	СТа	abno	rmali	ties t	that p	ersis	st wh	en si	table																
	Chro	nic lu	ıng di	seas	se (G	6A < 3	32 w	eeks	and	requ	ired	oxyg	en fo	or at l	east	first 2	28 da	ys af	fter b	irth)									
	(Spe	cify D	Diagno	osis	Cod	e)																							
	AND	: has	requ	ired	any	of the	e follo	owin	g the	rapie	s wit	thin t	he p	ast 6	mon	ths:													
		Supp	lemei	ntal	oxyg	en]	St	eroic	ls (sy	/sten	nic or	inhal	ed)												
		Mech	anica	al vei	ntilat	ion]	Di	ureti	cs																
	*CLE infec		ot ast	hma	a, cro	up, r	ecurr	ent (uppe	r resp	oirato	ory in	fecti	ons,	chror	nic bro	onchi	itis, c	chror	ic br	onch	iolitis	s, or a	a hist	tory o	fapı	revio	us RS	SV

Fax this form to 1-866-940-7328

Pharmacy PA Call Center: 1-855-258-1593

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (via return fax) immediately and arrange for the return or destruction of these documents. Distribution, reproduction or any other use of this transmission by any party other than the intended recipient is strictly prohibited.



FLORIDA MEDICAID

Prior Authorization SYNAGIS[®] – All Florida Regions Combined

Coverage Period: Based upon the specific region per the FLDOH website:

http://www.floridahealth.gov/diseases-and-conditions/respiratory-syncytial-virus/

Maximum number of doses: 5

Note: Form must be completed in full. An incomplete form may be returned.

	f ≤ 12 months old									
	Hemodynamically significant cyanotic or acyanotic congenital heart disease on medications to control CHF and will require surgery:									
	(Specify Diagnosis Code)									
	Moderate to severe pulmonary hypertension									
	f < 12 months old									
	< 29 completed weeks gestational age at birth (otherwise healthy)									
Dia	gnosis Code: ICD 10: P07.21 – P07.26									
	Chronic lung disease* (GA < 32 weeks): (Specify Diagnosis Code)									
	AND: required supplemental oxygen (for at least first 28 days after birth)									
	*CLD is not asthma, croup, recurrent upper respiratory infections, chronic bronchitis, chronic bronchiolitis, or a history of a previous RS infection.									
	Severe neuromuscular disease									
	(Specify Diagnosis code)									
	Congenital anomalies of the airways									
	(Specify Diagnosis code)									
	Profoundly immunocompromised									
	(Specify Diagnosis code)									
	Cystic Fibrosis with CLD and/or nutritional compromise									

Prescriber's Signature:

Date: _

REQUIRED FOR REVIEW: Copies of medical records (e.g., diagnostic evaluations and recent chart notes), the most recent copies of related labs, and supporting documentation for clinically appropriate submissions.

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

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 (100 mg and 50 mg).

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

All weights must be verified for dosing accuracy.

Pharmacy PA Call Center: 1-855-258-1593

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (via return fax) immediately and arrange for the return or destruction of these documents. Distribution, reproduction or any other use of this transmission by any party other than the intended recipient is strictly prohibited.