Michigan Department of Health and Human Services (MDHHS)

Prior Authorization Request

Synagis® *(palivizumab)*

All information on this form must be addressed. Incomplete forms will be returned only once for missing information. Mark as 'N/A' if no information is available or does not apply. Issues that remain blank after being returned once will receive a denial and will not qualify for MDHHS physician review until completed or clearly marked 'N/A'.

Beneficiary Information

LAST NAME: **FIRST NAME:**

MEDICAID NUMBER: **DATE OF BIRTH:** – –

GENDER: **MALE** ☐ **FEMALE** ☐

Prescriber Information

LAST NAME: **FIRST NAME:**

PLEASE SELECT ONE: ☐ MD ☐ PA ☐ NP ☐ DO ☐ DDS ☐ **OTHER:**

NPI NUMBER: **SPECIALTY:**

PHONE NUMBER: – – **FAX NUMBER:** – – –

Person Completing Form

LAST NAME: **FIRST NAME:**

TITLE:

PHONE NUMBER: – – **FAX NUMBER:** – – –

DATE: **REQUESTED START DATE:**

Pharmacy

NAME:

PHONE NUMBER: – – **FAX NUMBER:** – – –

Drug Name	Strength	Duration of Rx
Synagis®		November 1 through March 31

PLEASE DOCUMENT THE PATIENT'S WEIGHT (IN KILOGRAMS):

PLEASE DOCUMENT THE GESTATIONAL AGE:

CHECK APPLICABLE AGE AND CONDITION:

☐ Children < 12 months of age on November 1st of the current year and born < 29 weeks gestational age

☐ Children < 12 months of age on November 1st of the current year, with chronic lung disease (CLD) of prematurity, defined as < 32 weeks gestational age and requiring > 21% oxygen for at least 28 days after birth

- Percent of oxygen required _____ Duration of treatment _____

☐ Children < 24 months of age on November 1st of the current year with a history of chronic lung disease of prematurity (defined above) and who continued to receive medical treatment such as oxygen, chronic corticosteroids, or diuretic medications during the previous six months

- Percent of oxygen required _____ Date of last use _____ Duration of treatment _____
- Corticosteroid(s) prescribed _____ Date of last use _____
- Diuretic(s) prescribed _____ Date of last use _____

☐ Children < 12 months of age on November 1st of the current year, with hemodynamically significant cyanotic or acyanotic congenital heart disease

- Children receiving medication to control congenital heart failure who will require cardiac surgery
- Children with moderate to severe pulmonary hypertension
- Children with cyanotic heart disease

☐ Children < 12 months of age on November 1st of the current year, with pulmonary abnormalities or neuromuscular disease that affects the ability to clear secretions

☐ Children < 24 months of age on November 1st of the current year, who are severely immunocompromised (e.g., receiving chemotherapy) during RSV season

IF NONE OF THE ABOVE CONDITIONS APPLY, PLEASE PROVIDE DETAILS INCLUDING AGE (AS OF NOVEMBER 1ST), GESTATIONAL AGE AND ANY RISK FACTORS OR CONDITIONS.

Submit requests to:
Magellan Medicaid Administration
11013 W Broad Street Suite 500, Glen Allen, VA 23060
Fax: 888-603-7696 Phone: 877-864-9014
This form is available at michigan.fhsc.com → Providers → Forms

Revision Date: 10/2016

Magellan Rx MANAGEMENT℠