GEORGIA MEDICAID REQUIRED PA FORM FOR SYNAGIS -- FAX COMPLETED FORM TO I V CARE OPTIONS 866-374-6663

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GEORGIA MEDICAID FEE-FOR-SERVICE
Drug Evaluation Review Form

SYNAGIS PA REQUEST FORM

MUST BE COMPLETED BY PHYSICIAN AND FAXED TO OPTUMRX AT 1-888-491-9742

1. PATIENT INFORMATION

Last Name | First Name | M.I.

Street Address

City | State | ZIP

Day Telephone # (+Area Code) * | Night Telephone # (+Area Code)* | Mobile Telephone # (+Area Code)*

Date of Birth (MM/DD/YYYY) | Age | Gender (Check One) ☐M ☐F

Parent/Guardian Name

INSURANCE/MEDICAID INFORMATION

Primary/Medical Insurance/Medicaid | Secondary/Pharmacy Insurance

Cardholder Name & ID # (If Not Patient) | Cardholder Name & ID # (If Not Patient)

Group/Policy #* | Group/Policy #*

Insurance Telephone # (+Area Code)* | Insurance Telephone # (+Area Code)*

Employer* | Medicaid #

ALTERNATE SHIPPING ADDRESS*

Last Name | First Name | M.I.

Street Address | City | State | ZIP

2. PHYSICIAN INFORMATION

Prescriber's Last Name | Prescriber's First Name

Hospital/Clinic | Office Contact

Street Address

City | State | ZIP

Telephone # (+Area Code) | Fax # (+Area Code) | E-Mail Address

Prescriber's License # | DEA #

UPIN# | Medicaid License #

Primary Care Physician Name | Phone #

*Not required and/or necessary for Medicaid Fee-For-Service

STATEMENT OF MEDICAL NECESSITY – *COMPLETE FOR THE CURRENT RSV SEASON*

MEDICAL CRITERIA:

Gestational Age _____ Weeks _____ Days Birth Weight _____ g/kg/lbs
Current Weight _____ kg/lbs Date Recorded / /

Please Document All Diagnoses to the Highest Degree of ICD-10 Detail

1. Prematurity: ☐ Yes ☐ No Weeks of Gestation ICD-10 _____
☐ Gestational Age of < 29 Weeks (P07.21 – P07.26, P07.31) ☐ < 12 Months of Age at Start of RSV Season
☐ Gestational Age of 29 to < 32 Weeks (P07.32 – P07.34) ☐ < 24 Months of Age at Start of RSV Season

2. Chronic Lung Disease (CLD) of Prematurity (<32 Weeks' Gestation) AND < 24 Months of Age at Start of RSV Season: ☐ Yes ☐ No
☐ Chronic Respiratory Disease Originating in the Perinatal Period _____ ICD-10 _____
☐ Other Diagnosis (If Applicable) _____ ICD-10 _____
Did Patient Require Oxygen for First 28 Days After Birth?
☐ Yes ☐ No If Yes, what % oxygen was required? _____
Did Patient Receive Medical Support During 6-Month Period Before Start of RSV Season?
(Check All That Apply and Provide Last Date Received)
☐Oxygen: / / ☐Corticosteroid: / / ☐Diuretic: / /

3. Hemodynamically Significant Congenital Heart Disease (CHD) AND < 12 Months of Age at Start of RSV Season: ☐ Yes ☐ No
☐ CHD (Please Specify) _____ ICD-10 _____
☐ Other Diagnosis (If Applicable) _____ ICD-10 _____
Patient Has the Following Conditions (Check All That Apply):
☐ Acyanotic CHD ☐ Moderate-Severe Pulmonary Hypertension ☐ Cyanotic CHD
If Cyanotic CHD, Pediatric Cardiologist: _____ Office #: _____
☐ Medications for CHF: _____ Last Date Received / /
Cardiac Surgical Procedures: ☐ Yes ☐ No Describe: _____

4. Profoundly Immunocompromised AND < 24 Months of Age at Start of RSV Season: ☐ Yes ☐ No
☐ Bone Marrow Transplant ☐ Stem Cell Transplant
☐ Severe Immunodeficiency (Please Specify) _____ ICD-10 _____
☐ Neoplasm Receiving Chemotherapy (Please Specify) _____ ICD-10 _____
☐ Solid Organ Transplantation (Please Specify) _____ ICD-10 _____
☐ Other Diagnosis (If Applicable) _____ ICD-10 _____

5. Pulmonary Abnormality or Neuromuscular Disorder that Impairs Ability to Clear Secretions from Upper Airways AND < 12 months of Age at Start of RSV Season: ☐ Yes ☐ No
☐ Congenital Pulmonary Abnormality (Please Specify) _____ ICD-10 _____
☐ Other Pulmonary Abnormality (Please Specify) _____ ICD-10 _____
☐ Neuromuscular Disorder (Please Specify) _____ ICD-10 _____
Does Patient Have Ineffective Cough? ☐ Yes ☐ No

6. Cystic Fibrosis (CF) and < 24 Months of Age at Start of RSV Season: ☐ Yes ☐ No
☐ Cystic Fibrosis (Please Specify) _____ ICD-10 _____

OTHER RELEVANT MEDICAL HISTORY:

NICU HISTORY: ☐ No ☐ Yes NICU Name _____
If Yes, Please Attach the NICU Discharge Summary
Was There a NICU Dose Administered? ☐ No ☐ Yes Date / /
Did the Neonatologist Recommend Synagis Prior to Discharge? ☐ No ☐ Yes
Expected Date of First/Next Injection / /

PREVIOUS HEALTH PLAN/INSURANCE HISTORY:
Was Dose Administered in Previous Health Plan? ☐ No ☐ Yes # of Doses___ Last Date Received / /
Name of Previous Health Plan: _____ **Phone #:** _____

Rx
☐ **Synagis (palivizumab)** 50 and/or 100 mg Vials ☐ NKDA
Sig: Inject 15 mg/kg IM One Time Every 28 – 32 days
Dispense Quantity: QS ☐ Refill ____ Months
Product to be Administered In: ☐ Office ☑ Home Agency Nurse to Visit Home for Injection? ☐ No ☑ Yes
Was Dose Previously Administered in Office? ☐ No ☐ Yes # of Doses__ Last Date Received / /
☐ Other: _____

Prescriber's Signature (Must be signed by the physician. Stamped signature not allowed.) **Date**

3. FAX COMPLETED FORM TOLL-FREE TO OPTUMRX AT 1-888-491-9742

Revised August 2015

***** MEDICAID/OTHER PAYORS – PLEASE SEND APPROVAL OR DENIAL NOTICE TO I V CARE OPTIONS, FAX # 478-374-6663. THANK YOU.**