MISSISSIPPI DIVISION OF MEDICAID

PHARMACY PRIOR AUTHORIZATION FORM

Division of Medicaid
Pharmacy Prior Authorization Unit
550 High St., Suite 1000, Jackson, MS 39201

FAX TO: 1-877-537-0720

For Information Call:
1-877-537-0722

Beneficiary ID#: | | | | | | | | | | |

Beneficiary Full Name: _____ **DOB:**_____

Prescriber NPI: | | | | | | | | | | |

Prescriber's Full Name: _____ **Phone:** _____

Prescriber's Address: _____ **FAX:** _____

Pharmacy NPI: | | | | | | | | | | | **Phone:** _____

Pharmacy Name: _____ **FAX:** _____

CLINICAL INFORMATION

PA Start Date_____ **End Date**_____

Drug Requested _____**Strength**_____**Quantity**_____

Days Supply_____ **RX Refills**_____**Diagnosis or ICD-9 Code**_____

☐ **Hospital Discharge** ☐ **Additional Medical Justification Attached**

Medications received through coupons and/or samples are not acceptable as justification.

DRUG SPECIFIC INFORMATION

☐ Brand Name Multi Source (Must include MedWatch page and Brand Name Multi Source Page 2 from instructions)
☐ Enteral Nutrition (Must include Enteral Page2 from instructions)
☐ Synagis (Must include Synagis Page 2 from instructions)
☐ Children (Must include Children's Page 2 from instructions)
☐ Max Unit Override (Must include Max Override Page 2 from instructions)
☐ Early Refill (Must include Early Refill Page 2 from instructions)
☐ Preferred Drug List Exception Request (Must include Preferred Drug List Exception Page 2 from instructions)
☐ Appeal/Reconsideration (Must include Appeal/Reconsider information page 2 from Instructions)
☐ Other

MUST SUBMIT PAGE TWO
Prescribing provider's signature (signature and date stamps, or the signature of anyone other than the provider, are not acceptable)

Signature required: _____ **Date:** _____

Printed name of prescribing provider: _____

I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified in this form and I deem the prescribed medication to be necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil penalties, fines or criminal prosecution.

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Synagis Prior Authorization Form*

Injections approved starting October 29, 2013 - March 31, 2014 for a maximum of up to 5 injections

PHARMACY INFORMATION – Synagis® is available through a limited distribution network established by the manufacturer. The following list includes approved pharmacy providers from the 2013-2014 seasons. If the approved provider for this request is not included in this list, please select other and provide pharmacy provider information (name, address, telephone number, Medicaid provider number, etc.).

☐Lincare ☐MEDFUSION (BriovaRx) ☐NMMC ☐UMC ☐VitalCare

☐Other NPI:_____ PH:_____ Fax:_____

NDC#:_____Gestational Age: _____ Wks ____ Days Birth Weight: _____lbs. ____oz.

Current Weight: _____lbs. ____oz. Date last weighed: _____

Did the patient receive Synagis in the hospital? Yes ____ No ____ if yes, list date(s) of administration:

*_____

Risk Factors: Check all that apply.

☐**Chronic Lung Disease with a diagnosis of BPD requiring medical treatment within the past six months prior to RSV season** (e.g. diuretics, systemic steroids, oxygen on continuous basis, bronchodilators or ventilator dependent). Chronic Lung Disease (CLD) also known as bronchopulmonary dysplasia (BPD): an infant less than 32 weeks' gestation evaluated at 36 weeks' postmenstrual age or an infant of more than 32 weeks' gestation evaluated at more than 28 days but less than 56 days of age who has been receiving supplemental oxygen for more than 28 days. CLD of prematurity of is defined as CLD with gestational age less than 35 weeks. High risk is defined as those who receive treatment for CLD within the previous 6 months prior to RSV season, specifically treatment with corticosteroids, diuretics, bronchodilators or oxygen**. Note***: CLD **does not** include croup, URI, bronchitis, bronchiolitis, asthma, or wheezing.*

☐**Hemodynamically Significant Congenital Heart Disease**. **(CHD)**: children with congenital heart disease who are receiving medication to control congestive heart failure, have moderate to severe pulmonary hypertension, or have cyanotic heart disease. Decisions regarding prophylaxis with Synagis in children with CHD should be made on the basis of the degree of the physiologic cardiovascular compromise.

*****Supporting documentation must be submitted with request*****

☐Severe neuromuscular disease – up to 12 months
☐ Congenital abnormality of the airway – up to 12 months
☐Is the child in Day Care?
☐Does the child have siblings who are permanent resident in the home and less than 5 years old?

**** MS Division of Medicaid requires that all information requested on this form be completed for consideration of approval.***

Mississippi Medicaid is a federally-subsidized health care program funded with public dollars. As such, I confirm that this medication will be administered to the patient for whom it is dispensed. If I or my staff are unable to administer this medication to the designated patient, I acknowledge that I am responsible for notifying the dispensing pharmacy immediately