MISSISSIPPI DIVISION OF MEDICAID

STANDARDIZED ONE PAGE PHARMACY PRIOR AUTHORIZATION FORM

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

☐ **Medicaid Fee for Service**/Change Healthcare **Fax to: 1-877-537-0720** Ph: 1-877-537-0722
https://medicaid.ms.gov/providers/pharmacy/pharmacy-prior-authorization/

☐ **Magnolia Health**/Envolve Pharmacy Solutions
Fax to: 1-877-386-4695 Ph: 1-866-399-0928
https://www.magnoliahealthplan.com/providers/pharmacy.html

☐ **UnitedHealthcare**/OptumRx
Fax to: 1-866-940-7328 Ph: 1-800-310-6826
http://www.uhccommunityplan.com/health-professionals/ms/pharmacy-program.html

☐ **Molina Healthcare**/CVS Caremark
Fax to: 1-844-312-6371 Ph: 1-844-826-4335
http://www.molinahealthcare.com/providers/ms/medicaid/pages/home.aspx

BENEFICIARY INFORMATION	
Beneficiary ID: ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___	**DOB: ___ ___ / ___ ___ / ___ ___ ___ ___**
Beneficiary Full Name:	
PRESCRIBER INFORMATION	
Prescriber's NPI:	
Prescriber's Full Name:	**Phone:**
Prescriber's Address:	**FAX:**
PHARMACY INFORMATION	
Pharmacy NPI:	
Pharmacy Name:	
Pharmacy Phone:	**Pharmacy FAX:**

CLINICAL INFORMATION

Requested PA Start Date:_____ **Requested PA End Date:**_____

Drug/Product Requested:_____ **Strength:**_____ **Quantity:**_____

Days Supply:_____ **RX Refills:**_____ **Diagnosis or ICD-10 Code(s):**_____

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

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

PLEASE COMPLETE AND FAX DRUG SPECIFIC CRITERIA/ADDITIONAL DOCUMENTATION FORM FOUND BELOW

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

I certify that all information provided is accurate and appropriately documented in the patient's medical chart.

Signature required: _____ **Date:** _____

Printed name of prescribing provider:_____

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2020-21 Mississippi Division of Medicaid Synagis® Prior Authorization Criteria*

Beneficiaries must meet at least one of the bullet point criteria for age at the beginning of the RSV season: Oct 26, 2020

Age ≤ 1 year at start of RSV season and one of the following:

- ◯ Prematurity of ≤ 28 weeks 6 days gestation
- ◯ Documentation of **chronic lung disease** (CLD) of prematurity (defined as gestational age of 29 weeks 0 days – 31 weeks 6 days **AND** requirement for > 21% oxygen or chronic ventilator therapy for at least the first 28 days after birth).
- ◯ Documentation of **hemodynamically significant congenital heart disease (CHD) AND** one of the following:
  - (1) **acyanotic heart disease** receiving medication for congestive heart failure **AND** will require cardiac surgery.
  - (2) **moderate to severe pulmonary** hypertension.
  - (3) documentation of **cyanotic heart disease** through consultation with pediatric cardiologist.
- ◯ Documentation of **congenital abnormalities of the airway OR neuromuscular disease** that impairs the ability to clear secretions from the upper airway because of ineffective cough.
- ◯ Documentation of **cystic fibrosis AND** clinical evidence of CLD (defined as gestational age of 29 weeks 0 days – 31 weeks 6 days **AND** requirement for oxygen >21% for at least the first 28 days after birth) **OR** nutritional compromise.
- ◯ Documentation of **profound immunocompromise** (includes, but is not limited to, patients undergoing stem cell transplantation, chemotherapy) during the RSV season.

Age 12 – 24 months at start of RSV season and one of the following:

- ◯ Documentation of **chronic lung disease** (CLD) of prematurity (defined as gestational age ≤ 31 weeks 6 days **AND** requirement for > 21% oxygen or chronic ventilator therapy for at least the first 28 days after birth) **AND** required continued medical support (defined as chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) during the 6-month period before the RSV season.
- ◯ Documentation of **cystic fibrosis AND** one of the following:
  - (1) manifestations of **severe lung disease** (previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest radiography or chest computed tomography that persists when stable).
  - (2) weight for length < 10th percentile.
- ◯ Documentation of **profound immunocompromise** (includes, but is not limited to, patients undergoing stem cell transplantation, chemotherapy or organ transplants) during the RSV season.

Coverage limitations:

- ◯ PA requests for Synagis will be approved starting at the onset of RSV season for a maximum of up to 5 doses and a dosing interval not less than 30 days between injections. PA requests will be accepted starting October 5, 2020 for dates of service starting October 26, 2020.
- ◯ Synagis® will NOT be authorized for administration prior to October 26, 2020. Synagis® dosing authorizations will extend for the recommended number of doses OR until the end of epidemic RSV season as defined by CDC - whichever occurs first.

NOTES:

- Prophylaxis in infants with Down Syndrome is not recommended without the presence of one of the criteria listed above.

* American Academy of Pediatric Committee on Infectious Diseases and Bronchiolitis Guidelines Committee. Updated Guidance for Palivizumab Prophylaxis Among Infants and Young Children at Increased Risk of Hospitalization for Respiratory Syncytial Virus Infection. *Pediatrics.* Available at http://pediatrics.aappublicaions.org/content/early/2014/07/23/peds.2014-1665.

CRITERIA/ADDITIONAL DOCUMENTATION
RSV-SYNAGIS

MISSISSIPPI DIVISION OF MEDICAID

BENEFICIARY INFORMATION

Beneficiary ID:___ ___ ___ - ___ ___ ___ - ___ ___ ___ **DOB:**___ ___ /___ ___ /___ ___ ___ ___

Beneficiary Full Name:

RSV-SYNAGIS® CRITERIA/ADDITIONAL DOCUMENTATION*

PA requests will be accepted starting October 5, 2020 for dates of service starting October 26, 2020.
Synagis® will not be authorized for administration prior to October 26, 2020. PA requests will be approved starting at the onset of RSV season for a maximum of up to 5 doses, given monthly, per RSV season. A dosing interval *not less than 30 days* between injections is suggested.
Synagis® dosing authorizations will extend for the recommended number of doses *OR* until the end of epidemic RSV season as defined by CDC - *whichever occurs first*. DOM will notify providers when the end of the RSV season is determined.

PA REQUEST INFORMATION:

PHARMACY INFORMATION – Synagis® is available through a limited distribution network established by the manufacturer. The following list includes previously approved pharmacy providers. If the requesting pharmacy provider is not included in this list, select "Other" and provide pharmacy information including name, address, telephone number, Medicaid provider number, etc.

☐ Acaria Health ☐ Accredo ☐ Avella Specialty Pharmacy ☐ BriovaRx Specialty Pharmacy ☐ CVS Specialty Pharmacy ☐ UMMC
☐ Vital Care ☐ Other NPI: _____ PH: _____ FAX: _____ _____

Synagis Dosing Regimen: 15mg/kg IM once a month Product Availability: single dose vial: 50mg/0.5ml, 100mg/1 ml

Birth Date: _____ Gestational Age: _____ wks: _____ days: _____ Birth Weight: _____lbs. _____oz.

NDC#: _____ Current Weight: _____lbs. _____oz. Date last weighed: _____ _____

Did the patient receive Synagis in the hospital? Yes _____ No _____ If "Yes", list date(s) of administration: _____

Has the patient been hospitalized due to RSV at any time since the start of the current RSV season? Yes _____ No _____
Monthly prophylaxis should be discontinued for any infant or young child who experiences a breakthrough RSV hospitalization.

Check the criteria used to qualify the patient for Synagis®. All information requested on PA form must be completed for approval consideration.

Age ≤ 1 year at start of RSV season and one of the following:

- ◯ Prematurity of ≤ 28 weeks 6 days gestation.
- ◯ Documentation of **chronic lung disease** (CLD) of prematurity*.
- ◯ Documentation of **hemodynamically significant CHD AND** one of the following:
  - (1) **Acyanotic heart disease** receiving medication for congestive heart failure **AND** will require cardiac surgery.
  - (2) **Moderate to severe pulmonary** hypertension.
  - (3) Documentation of **cyanotic heart disease** through consultation with pediatric cardiologist.
- ◯ Documentation of **congenital abnormalities of the airway OR neuromuscular disease** that impairs the ability to clear secretions from the upper airway because of ineffective cough.
- ◯ Documentation of **cystic fibrosis AND** clinical evidence of CLD of prematurity* **OR** nutritional compromise.

Documentation of being **profoundly immunocompromised**** during the RSV season.

Age 12 – 24 months at start of RSV season and one of the following:

- ◯ Documentation of **chronic lung disease** (CLD) of prematurity* **AND** required continued medical support** during the 6-month period before the RSV season.
- ◯ Documentation of **cystic fibrosis AND** one of the following:
  - (1) Manifestations of **severe lung disease****.
  - (2) Weight for length < 10th percentile.

Documentation of being **profoundly immunocompromised**** during the RSV season.

Chronic lung disease of prematurity defined as gestational age ≤ 31 weeks 6 days AND requirement for oxygen >21% or chronic ventilator therapy for at least the first 28 days after birth. ** Refer to 2020-21 Division of Medicaid Synagis® PA Criteria Instructions for more detailed definitions. Reference: Pediatrics 2014:134; 415 originally published online July 28, 2014.

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