



# 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.uhcommunityplan.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: \_\_\_\_\_

### FAX THIS PAGE

SUBMISSION AND/OR APPROVAL OF A DRUG PRIOR AUTHORIZATION REQUEST DOES NOT GUARANTEE MEDICAID PAYMENT FOR PHARMACY PRODUCTS OR THE AMOUNT OF PAYMENT. ELIGIBILITY FOR AND PAYMENT OF MEDICAID SERVICES ARE SUBJECT TO ALL TERMS AND CONDITIONS AND LIMITATIONS OF THE MEDICAID PROGRAM.

**Confidentiality Notice:** This communication, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply telephone (1-877-537-0722) or fax (1-877-537-0720) and destroy all copies of the original message.

7/29/2022



# 2021-22 Mississippi Division of Medicaid Synagis® Prior Authorization Criteria\*

**Beneficiaries must meet at least one of the bullet point criteria for age at time of request.**

**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 < 10<sup>th</sup> 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 for a dosing interval not less than 30 days between injections.

**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



### BENEFICIARY INFORMATION

Beneficiary ID: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Beneficiary Full Name: \_\_\_\_\_

### RSV-SYNAGIS® CRITERIA/ADDITIONAL DOCUMENTATION\*

For dosing outside the traditional fall to spring season, PA requests will be approved for 2 doses administered at a dosing interval ***not less than 30 days*** between injections. Additional doses may be approved at a later date if elevated prevalence of community RSV continues.

### 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 May 1, 2022? 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 < 10<sup>th</sup> 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.**

## FAX THIS PAGE

SUBMISSION AND/OR APPROVAL OF A DRUG PRIOR AUTHORIZATION REQUEST DOES NOT GUARANTEE MEDICAID PAYMENT FOR PHARMACY PRODUCTS OR THE AMOUNT OF PAYMENT. ELIGIBILITY FOR AND PAYMENT OF MEDICAID SERVICES ARE SUBJECT TO ALL TERMS AND CONDITIONS AND LIMITATIONS OF THE MEDICAID PROGRAM.

**Confidentiality Notice:** This communication, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply telephone (1-877-537-0722) or fax (1-877-537-0720) and destroy all copies of the original message.