STANDARDIZED ONE PAGE PHARMACY PRIOR AUTHORIZATION FORM

Mississippi Division of Medicaid, Pharmacy Prior Authorization Unit, PO Box 2480, Ridgeland, MS 39158

☐ Medicaid Fee for Service/Gainwell Technologies
Fax to: 1-866-644-6147 Ph: 1-833-660-2402
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

![Image 38x749 to 162x791]

BENEFFICIARY INFORMATION


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.

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10/1/2022
### Beneficiaries must meet at least one of the bullet point criteria for age at time of request.

<table>
<thead>
<tr>
<th>Age ≤ 1 year at start of RSV season and one of the following:</th>
<th>Age 12 – 24 months at start of RSV season and one of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Prematurity of ≤ 28 weeks 6 days gestation</td>
<td>○ Documentation of chronic lung disease (CLD) of prematurity (defined as gestational age ≤ 31 weeks 6 days AND requirement for &gt; 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.</td>
</tr>
<tr>
<td>○ Documentation of chronic lung disease (CLD) of prematurity (defined as gestational age of 29 weeks 0 days – 31 weeks 6 days AND requirement for &gt; 21% oxygen or chronic ventilator therapy for at least the first 28 days after birth).</td>
<td>○ Documentation of cystic fibrosis AND one of the following:</td>
</tr>
<tr>
<td>○ Documentation of hemodynamically significant congenital heart disease (CHD) AND one of the following:</td>
<td>(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).</td>
</tr>
<tr>
<td>(1) acyanotic heart disease receiving medication for congestive heart failure AND will require cardiac surgery.</td>
<td>(2) weight for length &lt; 10th percentile.</td>
</tr>
<tr>
<td>(2) moderate to severe pulmonary hypertension.</td>
<td>○ Documentation of profound immunocompromise (includes, but is not limited to, patients undergoing stem cell transplantation, chemotherapy, or organ transplants) during the RSV season.</td>
</tr>
<tr>
<td>(3) documentation of cyanotic heart disease through consultation with pediatric cardiologist.</td>
<td>○ Documentation of profound immunocompromise (includes, but is not limited to, patients undergoing stem cell transplantation, chemotherapy) during the RSV season.</td>
</tr>
<tr>
<td>○ 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.</td>
<td></td>
</tr>
<tr>
<td>○ 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 &gt;21% for at least the first 28 days after birth) OR nutritional compromise.</td>
<td></td>
</tr>
<tr>
<td>○ Documentation of profound immunocompromise (includes, but is not limited to, patients undergoing stem cell transplantation, chemotherapy) during the RSV season.</td>
<td></td>
</tr>
</tbody>
</table>

**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 Tuesday, October 11, 2022, for dates of service starting Tuesday, November 1, 2022.
- Synagis® will NOT be authorized for administration prior to November 1, 2022; this refers to the typical season and excludes off-season case-by-case authorizations. 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. Monthly prophylaxis should be discontinued for any infant or young child who experiences a breakthrough RSV hospitalization.

**NOTE:**

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

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CRITERIA/ADDITIONAL DOCUMENTATION
RSV-SYNAGIS 2022-23

**ELIGIBILITY FOR AND PAYMENT OF MEDICAID SERVICES ARE SUBJECT TO ALL TERMS AND CONDITIONS AND LIMITATIONS OF THE MEDICAID PROGRAM.**

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**CRITERIA/ADDITIONAL DOCUMENTATION**

**Beneficiary ID:** _______ _______ - _______ _______ - _______ _______  
**DOB:** _______ / _______ / _______ _______ _______

**Beneficiary Full Name:**

**PA REQUEST INFORMATION:**

**PHARMACY INFORMATION – Synagis® is available through a limited distribution network established by the manufacturer.**

**Synagis Dosing Regimen:**

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

**Birth Date:** ___________  
**Gestational Age:** _______ weeks: _______ 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:
  - Acyanotic heart disease receiving medication for congestive heart failure AND will require cardiac surgery.
  - Moderate to severe pulmonary hypertension.
  - Documentation of cyanotic heart disease through consultation with pediatric cardiologist.
- Documentation of congenital abnormalities of the airway OR neuromuscular disease thatimpairs 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:
  - Manifestations of severe lung disease**.
  - 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 2022-23 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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