

FLORIDA MEDICAID

Prior Authorization SYNAGIS® – All Florida Regions Combined

Coverage Period: Based upon the specific region per the FLDOH website:

http://www.floridahealth.gov/diseases-and-conditions/respiratory-syncytial-virus/

Maximum number of doses: 5

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID#						_		Date	Date of Birth (MM/DD/YYYY)																				
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Rec	ipien	t's F	ull N	ame		1		<u> </u>		J]]		1	1									
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Pre	scrib	er′s	Full	Nam	e 																								
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Pre	scrib	er's	NPI							1																			
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			_				-														_				_				
Syr	nagis	Vial (Qty:																										
SIG: Inject 15 mg/kg IM once monthly Start Da																Refill(s):mos													
☐ 100 mg ☐ 50 mg Birth						h We	ight:	ht:							Current Weight:														
									Ges	tatio	nal A	.ge (0	GA) :																
	f < 2	4 mo	nths	old																									
	Cardia	ac tra	nspla	ant d	uring	RS∖	/ sea	son																					
	Alread	ly on	prop	hyla	xis aı	nd eli	igible	; give	e pos	st-op	dose	afte	r card	diac	bypa	ss or	afte	r ECI	MO										
□ F	Profou	ındly	lmm	unoc	omp	romis	sed		(S	pecit	fy Dia	agno	sis Co	ode)															
I	f > 12	mor	nths o	old ar	nd <	24 m	onth	s old																					
	Cyst																												
	AND									-																			
		Nutri	tiona	l con	npror	nise	(weig	tht fo	r len	gth <	10 th	perc	entile))															
		Hosp	italiz	ation	for p	oulmo	onary	exa	cerba	ation	in fir	st ye	ar of	life															
		Ches	t X-r	ay or	CT	abno	rmali	ties t	hat p	ersis	st wh	en st	able																
	Chro	nic I	ung c	lisea	se (G	A <	32 w	eeks	and	requ	ired o	oxyg	en foi	r at le	east	first 2	28 da	ys af	fter b	irth)									
	(Spe	cify [Diagr	osis	Cod	e)										_													
	AND	: has	requ	uired	any	of the	e follo	owing	g the	rapie	s wit	hin th	ne pa	st 6	mon	ths:													
		Supp	leme	ental	oxyg	en]	Ste	eroid	s (sy	stem	ic or	inhal	ed)												
		Mech	nanic	al ve	ntilat	ion]	Di	uretio	cs																
	*CLE		ot as	thma	a, cro	up, r	ecurr	ent u	ıppeı	r resp	oirato	ry in	fectio	ns, c	chror	nic bro	onch	itis, c	hron	ic br	onch	iolitis	, or a	a hist	ory o	f a p	revio	us R	SV

Mail or Fax Information to:

Prime Therapeutics State Government Solutions LLC
Prior Authorization
P. O. Box 7082

Tallahassee, FL 32314-7082 Phone: 877-553-7481 Fax: 877-614-1078 **Confidentiality Notice:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (via return fax) immediately and arrange for the return or destruction of these documents. Distribution, reproduction or any other use of this transmission by any party other than the intended recipient is strictly prohibited.



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ا 🔲	f ≤ 12 months old								
	Hemodynamically significant cyanotic or acyanotic congenital heart disease on medications to control CHF and will require surgery:								
	(Specify Diagnosis Code)								
	Moderate to severe pulmonary hypertension								
ا 🗆	f < 12 months old								
	< 29 completed weeks gestational age at birth (otherwise healthy)								
Dia	gnosis Code: ICD 10: P07.21 – P07.26								
	Chronic lung disease* (GA < 32 weeks): (Specify Diagnosis Code)								
	☐ AND: required supplemental oxygen (for at least first 28 days after birth)								
	*CLD is not asthma, croup, recurrent upper respiratory infections, chronic bronchitis, chronic bronchiolitis, or a history of a previous RSV infection.								
	Severe neuromuscular disease								
	(Specify Diagnosis code)								
	Congenital anomalies of the airways								
	(Specify Diagnosis code)								
	Profoundly immunocompromised								
	(Specify Diagnosis code)								
	Cystic Fibrosis with CLD and/or nutritional compromise								
Pre	scriber's Signature: Date:								
	REQUIRED FOR REVIEW: Copies of medical records (e.g., diagnostic evaluations and recent chart notes), the most recent copies of related labs, and supporting documentation for clinically appropriate submissions.								
	The provider must retain copies of all documentation for five years.								
	The provider much retain copies of an accumentation for the years.								
On	NOTE: Pharmacies should not submit separate claims for different dosage strength vials to be administered on the same date. Only one compound claim submission will be necessary. For example, if the Synagis dosage is 150 mg, the pharmacy should submit a compound claim that lists the two different strength vials (100 mg and 50 mg).								
We	ight Criteria for Synagis [®] (palivizumab): (Refer to <i>Weight Change Form</i>)								
ΑII	weights must be verified for dosing accuracy.								

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