



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#

Grid for Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY)

Grid for Date of Birth

Recipient's Full Name

Grid for Recipient's Full Name

Prescriber's Full Name

Grid for Prescriber's Full Name

Prescriber's NPI

Grid for Prescriber's NPI

Prescriber Phone Number

Grid for Prescriber Phone Number

Prescriber Fax Number

Grid for Prescriber Fax Number

Synagis Vial Qty:

SIG: Inject 15 mg/kg IM once monthly

100 mg 50 mg

Start Date:

Refill(s): mos

Birth Weight: lbs / kgs

Current Weight: lbs / kgs

Gestational Age (GA):

If < 24 months old

Cardiac transplant during RSV season

Already on prophylaxis and eligible; give post-op dose after cardiac bypass or after ECMO

Profoundly Immunocompromised (Specify Diagnosis Code)

If > 12 months old and < 24 months old

Cystic Fibrosis

AND: must meet at least one of the following criteria

Nutritional compromise (weight for length < 10th percentile)

Hospitalization for pulmonary exacerbation in first year of life

Chest X-ray or CT abnormalities that persist when stable

Chronic lung disease (GA < 32 weeks and required oxygen for at least first 28 days after birth)

(Specify Diagnosis Code)

AND: has required any of the following therapies within the past 6 months:

Supplemental oxygen Steroids (systemic or inhaled)

Mechanical ventilation Diuretics

*CLD is not asthma, croup, recurrent upper respiratory infections, chronic bronchitis, chronic bronchiolitis, or a history of a previous RSV infection.

Mail or Fax Information to:

Magellan Medicaid Administration, Inc.
Prior Authorization
P. O. Box 7082
Tallahassee, FL 32314-7082
Phone: 877-553-7481
Fax: 877-614-1078

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If ≤ 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

If < 12 months old

- < 29 completed weeks gestational age at birth (otherwise healthy)

Diagnosis 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

Prescriber'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.

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).

Weight Criteria for Synagis® (palivizumab): (Refer to *Weight Change Form*)

All weights must be verified for dosing accuracy.

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