PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Synagis SWHP 2018-2019

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Member gestational age (weeks and days) at birth:

Q2. Member age at START of RSV season:

☐ <12 months ☐ 12 to 24 months ☐ >24 months

Q3. Has member received a Synagis prophylactic injection during hospitalization since the start of the CURRENT RSV season?

☐ Yes ☐ No

Q4. If answered 'yes' to question #3, please specify number of injections (doses) received:

Q5. Does the member have an active diagnosis of chronic lung disease (CLD) of prematurity (defined as: born < 32 weeks, 0 days gestational age and required >21% oxygen for at least 28 days after birth) AND required treatment with any of the following therapies within the 6 months prior to the current RSV season: [Select all that apply]

☐ > 21% supplemental oxygen
☐ Chronic systemic corticosteroids, diuretics, or bronchodilator therapy
☐ Long-Term Mechanical Ventilation

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☐ None of the above
☐ N/A - patient does not have an active diagnosis of CLD of prematurity

Q6. Has the member been profoundly immunocompromised during the RSV season defined as meeting ONE of the following criteria: solid organ or hematopoietic stem cell transplant, chemotherapy or other condition that leaves the infant profoundly immunocompromised (provide ICD 10 code)?

☐ Yes ☐ No

Q7. Was the member born prematurely, defined as born < 29 weeks 0 days gestational age at birth?

☐ Yes ☐ No

Q8. Does the member have a diagnosis of chronic lung disease (CLD) of prematurity (born < 32 weeks, 0 day gestational age and require >21% oxygen for at least 28 days after birth)?

☐ Yes ☐ No

Q9. Does the member have severe congenital abnormality of airway OR severe neuromuscular disease that impairs his/her ability to clear secretions from the upper airway because of ineffective cough?

☐ Yes ☐ No

Q10. Does the member have cystic fibrosis and meet at least ONE of the following: [Select all that apply]

☐ Clinical evidence of CLD and/or nutritional compromise (i.e. failure to thrive)
☐ Severe lung disease, defined as previous hospitalization for pulmonary exacerbation in the first year of life, abnormalities on chest radiography or chest computed tomography that persists when stable)
☐ Weight for length <10th percentile on pediatric growth chart
☐ None of the above
☐ N/A - patient does not have cystic fibrosis

Q11. Does the member have an active diagnosis of hemodynamically significant congenital heart disease defined as meeting one of the following: [Select All that Apply]

☐ Acyanotic heart disease, requiring medication to control CHF, and will require a cardiac surgical procedure
☐ Moderate to severe Pulmonary Hypertension
☐ Cyanotic congenital heart disease (in consultation with a pediatric cardiologist)
☐ Undergone a cardiac transplantation during the RSV season
☐ None of the above
☐ N/A - patient does not have an active diagnosis of hemodynamically significant congenital heart disease

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Q12. Has the member experienced a breakthrough RSV hospitalization during the CURRENT RSV season?

☐ Yes ☐ No

Q13. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement?

☐ Pharmacy
☐ Individual prescriber
☐ Provider or specialty group
☐ Facility
☐ Other (please specify)

Q14. Provide name and NPI of the billing entity

Q15. Will the claim for the drug be submitted as a MEDICAL claim or PHARMACY claim (Note: If a pharmacy will be submitting a MEDICAL claim for drug reimbursement, answer MEDICAL)?

☐ Medical ☐ Pharmacy

Q16. Additional comments:

Prescriber Signature

Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

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