

**FAX TO: 1-800-459-2135**

HEALTH INFORMATION DESIGNS, INC.  
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Phone: (800) 355-0486

**2009 - 2010 SYNAGIS**

PRIOR AUTHORIZATION REQUEST FORM  
October 26 - March 31 for a maximum of 5 injections

**BENEFICIARY INFORMATION**

Beneficiary's Name: \_\_\_\_\_ Beneficiary's Medicaid #: \_\_\_\_\_

DOB: \_\_\_\_\_ City: \_\_\_\_\_  
Month Day 4 Digit Year

**PRESCRIBER INFORMATION**

Prescribing Physician: \_\_\_\_\_

NPI #: \_\_\_\_\_

Medicaid ID #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

*Mississippi Medicaid is a federally-subsidized health care program funded with public dollars. As such, I confirm that this medication will be administered to the patient for whom it is dispensed. If I or my staff are unable to administer this medication to the designated patient, I acknowledge that I am responsible for notifying the dispensing pharmacy immediately.*

*I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified in this form and I deem the prescribed medication to be necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil penalties, fines or criminal prosecution.*

\_\_\_\_\_  
Physician's Signature and date

**PHARMACY INFORMATION** – Synagis® is available through a limited distribution network established by the manufacturer. The following list includes approved pharmacy providers from the 2008-2009 season. If the preferred provider for this request is not included in this list, please select other and provide pharmacy provider information (name, address, telephone number, Medicaid provider number, etc.).

- |   |  |
|---|--|
| <input type="checkbox"/> Accredo (Memphis, TN)                                  | <input type="checkbox"/> Patio Healthcare (Metairie, LA)         |
| <input type="checkbox"/> Care Plus CVS (Chicago, IL)                            | <input type="checkbox"/> Transcript (Jackson, MS)                |
| <input type="checkbox"/> Medfusion (Columbus, MS)                               | <input type="checkbox"/> UMC Medical Mall Pharmacy (Jackson, MS) |
| <input type="checkbox"/> North Mississippi Medical Center Pharmacy (Tupelo, MS) | <input type="checkbox"/> VitalCare (Meridian, MS)                |
| <input type="checkbox"/> Other: _____   |  |

**DRUG/CLINICAL INFORMATION**

NDC#: \_\_\_\_\_ Gestational Age: \_\_\_\_\_ wks Birth Weight: \_\_\_\_\_ lbs \_\_\_\_\_ oz

Current Weight: \_\_\_\_\_ lbs \_\_\_\_\_ oz Date last weighed: \_\_\_\_\_

**First Season Requests:**

**Did the patient receive Synagis in the hospital? Yes \_\_\_ No \_\_\_ If Yes, list date(s) of administration: \_\_\_\_\_**

**Risk Factors:** Check all that apply to *first season* requests only.

- |  |  |
|--|--|
| <input type="checkbox"/> Chronic Lung Disease requiring medical treatment within the past six months (e.g. diuretics, systemic steroids, oxygen on continuous basis, bronchodilators or ventilator-dependent). | <input type="checkbox"/> Severe neuromuscular disease                          |
| <input type="checkbox"/> Hemodynamically Significant Congenital Heart Disease  | <input type="checkbox"/> Congenital abnormality of the airway                  |
|  | <input type="checkbox"/> Day Care  |
|  | <input type="checkbox"/> School Age Siblings (<5 years old) living in the home |

**Second Season Requests:**

**Risk Factors:** Check all that apply to *second season* requests only.

- |   |   |
|---|---|
| <input type="checkbox"/> Severe CLD requiring continued medical therapy | <input type="checkbox"/> HSCHD (hemodynamically significant congenital heart disease) |
|---|---|

Additional Rationale for Second Season: \_\_\_\_\_

\*\*\*Supporting documentation must be available in the patient record.

RSV prophylaxis approval will terminate at the end of RSV season. Authorization will end at age two (2) on the last day of the child's birthday month.

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