Universal Synagis Authorization Form

***Fax the COMPLETED form or call the plan with the requested information.**

Absolute Total Care	Advicare	BlueChoice HealthPlan Medicaid	FFS Medicaid	First Choice	Molina Healthcare	WellCare Health Plan
P: 866-433-6041 F: 855-865-9469	P: 866-814-5506 F: 866-249-6155	P: 866-902-1689 F: 800-823-5520	P:866-247-1181 F:888-603-7696	P: 866-610-2773 F: 866-610-2775	P: 855-237-6178 F: 855-571-3011	P: 888-588-9842 F: 866-354-8709

If the following information is not complete, correct, or legible, the PA process can be delayed. Use one form per member please.

Member Information

LAST NAME: **FIRST NAME:**

MEDICAID ID NUMBER: **DATE OF BIRTH:** – –

Prescriber Information

LAST NAME: **FIRST NAME:**

NPI NUMBER: **DEA NUMBER:**

PHONE NUMBER: – – **FAX NUMBER:** – – –

STRENGTH: ☐ 50 mg (NDC 60574411401) **QUANTITY:** **PA START DATE**

☐ 100 mg (NDC 60574411301) **QUANTITY** _____ **PA START DATE** _____

NAME OF DISPENSING PHARMACY: **NPI NUMBER:** _____

PHONE NUMBER: – – **FAX NUMBER:** – – –

Clinical Criteria Documentation *****Do **not** include documentation that is not requested on this form*****

1. **What was the patient's gestational age at birth, current weight, and gender?**

_____weeks _____days

_____kg or _____lb

☐ Male ☐ Female

3. **Does the patient have Chronic Lung Disease of Prematurity (Formerly called bronchopulmonary dysplasia)** ☐ Yes (go to question 3) ☐
4. **Did the patient receive oxygen immediately following birth?** ☐ Yes (go to question 4) ☐ No (go to question 6)
5. **Please indicate the % oxygen received, date received, and the duration of treatment**:
6. **Please indicate if patient is receiving any of the following respiratory support therapies on a daily basis:**
   - ☐ Oxygen Most recent date _____
   - ☐ Systemic corticosteroids Most recent date _____
   - ☐ Diuretics Most recent date _____
   - ☐ Bronchodilator Most recent date _____
7. **Does the patient have a diagnosis of Cystic Fibrosis?** ☐ Yes (submit documentation of pulmonary & nutritional status) ☐ No
8. **Please indicate if patient has any of the following:**
   - ☐ Anatomic Pulmonary Abnormality, specify: _____ ☐ Neuromuscular Disorder, specify:
   - ☐ Congenital anomaly that impairs the ability to clear secretions, specify:

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9. Please indicate if patient has any of the following:

☐ HIV ☐ Cancer, receiving chemotherapy ☐ Organ transplant receiving immunosuppressant therapy

☐ Other medical condition that is severely immunocompromising patient, (e.g. Children younger than 24 months who will be profoundly immunocompromised during the RSV season) please specify: _____

10. Has this patient received a heart transplant? ☐ Yes (date: ☐ No

11. Does patient have hemodynamically significant congenital heart disease? ☐ Yes (please indicate) ☐ No

☐ Acyanotic heart disease (specify: _____)

☐ Cyanotic heart disease (specify: _____; Name of Pediatric Cardiologist:_____)

☐ Pulmonary Hypertension ☐ Other:

_____

12. Will this patient's congenital heart disease require cardiac surgery? ☐ Yes ☐ No

13. Please list any medications that may be used:

☐ Ace-Inhibitor/ARB	Most recent date administered:	_____
☐ Diuretic	Most recent date administered:	_____
☐ Beta-blocker	Most recent date administered:	_____
☐ Digoxin	Most recent date administered:	_____
☐ Other cardiovascular medications (specify):		_____ _____

Please note any other information pertinent to this PA request: _____

_____

_____

_____

_____

_____ _____

Prescriber Signature (Required) ***Date***

*(**On behalf of the Prescriber or Pharmacy Provider, I **certify that the information stated above is a true statement, made for the purposes of inducing SC Medicaid to offer prescription coverage to this individual for the medication requested above. I understand that this document and any attached materials will be retained for the purposes of possible future audit).*