Reset Save Print

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Prior Authorization Request Form

Universal Synagis®

Form must be complete, correct, and legible or the PA process can be delayed.
Use one form per member, please.

Request Date: ____ / ____ / _____

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

Absolute Total Care	FFS Medicaid	First Choice	Healthy Blue by Blue Choice of SC	Humana Healthy Horizons of SC	Molina Healthcare
P: 866-433-6041 F: 855-865-9469	P: 866-247-1181 F: 888-603-7696	P: 866-610-2773 F: 866-610-2775	P: 844-345-2803 F: 866-494-9927	P: 800-555-2546 F: 877-486-2621	P: 855-237-6178 F: 855-571-3011

I. MEMBER INFORMATION

First Name | **Last Name**

Medicaid ID # | **Date of Birth (MM/DD/YYYY)** / / | **Sex** Male | Female

II. PRESCRIBER INFORMATION

Prescriber's First Name | **Prescriber's Last Name**

National Provider ID # (NPI) | **DEA Number**

Prescriber's Phone Number - - | **Prescriber's Fax Number** - -

III. PHARMACY INFORMATION

Name of Dispensing Pharmacy | **NPI #**

Pharmacy Phone Number - - | **Pharmacy Fax Number** - -

IV. DRUG INFORMATION

Strength: **50 mg (NDC 60574-4114-01)** **Quantity:** _____ **PA Start Date:** _____

100 mg (NDC 60574-4113-01) **Quantity:** _____ **PA Start Date:** _____

V. CLINICAL CRITERIA DOCUMENTATION *(**Do NOT include documentation that is not requested on this form**)*

1. **What was the patient's gestational age at birth?**

   _____ weeks _____ days **ICD Diagnosis Code:** _____

2. **What is the patient's current weight?**

   _____ kg **OR** _____ lb

3. **Does the patient have Chronic Lung Disease of Prematurity (formerly called bronchopulmonary dysplasia)?**

   Yes (go to question 4) No (go to question 6)

4. **Did the patient receive oxygen immediately following birth?**

   Yes (go to question 5) No (go to question 6)

5. **Indicate the % oxygen received, date received, and the duration of treatment**: _____

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Prior Authorization Request Form

Universal Synagis®

Form must be complete, correct, and legible or the PA process can be delayed.
Use one form per member, please.

6. Indicate if patient is receiving any of the following respiratory support therapies on a daily basis:

- ☐ Systemic corticosteroids — Most recent date: _____
- ☐ Diuretics — Most recent date: _____
- ☐ Bronchodilator — Most recent date: _____
- ☐ Oxygen — Most recent date: _____

7. Does the patient have a diagnosis of Cystic Fibrosis?

Yes — If yes, submit documentation of pulmonary and nutritional status
No

8. Does the patient have any of the following?

- ☐ Anatomic Pulmonary Abnormality. Please specify: _____
- ☐ Neuromuscular Disorder. Please specify: _____

9. Does the patient have 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 — Most recent date: _____
- ☐ 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. Please specify: _____

14. 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).