FAX completed form to
Goold Health Systems (GHS)
1-866-964-3472

Wyoming Medicaid – Pharmacy Services Program
MULTIPLE USE**
PRIOR AUTHORIZATION REQUEST FORM

PHONE:
(For questions or inquiries ONLY)
1-877-207-1126

SYNAGIS®

Provider must fill in all information below. It must be legible, correct and complete or the form will be returned.

Client ID #: |_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Client's Full Name: _____ DOB: _____

Prescriber NPI: |_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Prescriber's Full Name: _____ Phone: _____

Prescriber Address: _____ Fax: _____

Pharmacy NPI: |_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Pharmacy Name: _____ Phone: _____

Wyoming EqualityCare will approve Synagis® PA requests for clients that meet the guidelines below. Requests will be approved for a max of 5 doses at a dosing interval not less than 28 days between injections. Requests will be accepted November 1st for the start date of 11/15/10.

MEDICAL NECESSITY DOCUMENTATION *(Please check all that apply):*

☐ **CHRONIC LUNG DISEASE:** Client is ≤ 24 months of age at start of therapy and has chronic lung disease of prematurity (i.e. bronchopulmonary dysplasia) requiring medication (bronchodilator, diuretic, or chronic corticosteroid therapy) or oxygen within 6 months of the start of RSV season.

☐ **CONGENITAL HEART DISEASE:** Client is ≤24 months of age at start of therapy and has hemodynamically significant congenital heart disease and one or more of the following: (Please check all that apply)

- ☐ Is receiving medication to control congestive heart failure
- ☐ Has a diagnosis of moderate to severe pulmonary hypertension
- ☐ Has a diagnosis of cyanotic heart disease.

☐ **PREMATURITY:**

- ☐ Client is ≤12 months of age at start of RSV season and born at **≤28 weeks, 6 days** gestational age.
- ☐ Client is ≤12 months of age at start of RSV season and born at **34 weeks, 6 days or less** gestational age and has either severe neuromuscular disease or congenital abnormalities, either of which compromise handling of respiratory secretions.
- ☐ Client is ≤ 6 months of age at start of RSV season and born between **29 weeks, 0 days** and **35 weeks, 6 days** gestational age.

☐ **OTHER:** _____

Please indicate if the client has received a previous Synagis® dose in an inpatient setting. If yes, please provide the date(s) of administration:

☐No ☐Yes Administration Date(s):_____

****Please submit (by fax) the same PA form per client per season. After the initial PA has been approved, additional doses require ONLY the strength, date and weight to be filled in below.**

SYNAGIS®	STRENGTH	DAYS SUPPLY	ADMINISTRATION DATE	CLIENT'S WEIGHT	PROVIDER OR PROVIDER'S AGENT'S INITALS
1st Dose		28		**Lbs** **oz.**	
2nd Dose		28		**Lbs** **oz.**	
3rd Dose		28		**Lbs** **oz.**	
4th Dose		28		**Lbs** **oz.**	
5th Dose		28		**Lbs** **oz.**	

Provider Signature:_____Date(s) of Submission: _____ _____ _____ _____ _____

****MUST MATCH PROVIDER LISTED ABOVE*** ***1ST DOSE*** ***2ND*** ***3RD*** ***4TH*** ***5TH***

American Academy of Pediatrics-Website: http://aapredbook.aappublications.org/cgi/content/full/2009/1/3.110