

**TEXAS MEDICAID VENDOR DRUG PROGRAM
 SYNAGIS® (PALIVIZUMAB) PRIOR AUTHORIZATION REQUEST & PRESCRIPTION FORM for 2007**

Fax this form to the Texas Prior Authorization Call Center at 1-866-617-8864

Patient Name: _____		Texas Medicaid Recipient Number: _____	
Date of Birth: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone Number: _____ Telephone Number: _____	
Address: _____		City: _____	State: _____ Zip: _____
Parent/Legal Guardian (if applicable): _____			
Age In months at start of RSV season (As of October 1 st): _____ months		Estimated gestational age at birth: _____ completed weeks: ICD-9 Code: _____	
Current weight _____			
<input type="checkbox"/> If < 24 months chronological age at the start of the RSV season, can qualify based on criteria to the right. Diagnoses and conditions must be clearly documented in the patient's medical record Date of birth on or after 09/30/2005 (see Medicaid Bulletin #199 – Nov/Dec 2006 for details related to congenital heart disease diagnoses.)	<input type="checkbox"/> Hemodynamically significant heart disease: (Specify ICD-9 Code(s) _____) OR <input type="checkbox"/> Solid organ or stem cell transplant recipient: (Specify ICD-9 Code(s) _____) OR <input type="checkbox"/> Chronic lung disease: (Specify ICD-9 Code(s) _____) AND: Required any of the following therapies within the past 6 months <input type="checkbox"/> Supplemental oxygen <input type="checkbox"/> Steroids (systemic or inhaled) <input type="checkbox"/> Digitalis <input type="checkbox"/> Mechanical ventilation <input type="checkbox"/> Diuretics *Chronic lung disease (CLD) was formerly called bronchopulmonary dysplasia. It can develop in pre term neonates treated with oxygen and positive pressure ventilation. Many cases are seen in infants who previously had respiratory distress syndrome (RSD). CLD is characterized by disordered lung growth and a reduction in the number of structures available for gas exchange. CLD is not asthma, croup, recurrent upper respiratory infections, chronic bronchitis, chronic bronchiolitis, or a history of a previous RSV infection.		
<input type="checkbox"/> If < 12 months chronological age at the start of the RSV season, can qualify based on criteria to the right. Date of birth on or after 09/30/2006	<input type="checkbox"/> ≤ 28 Completed weeks gestational age at birth: (Specify ICD-9 Code): _____		
<input type="checkbox"/> If < 6 months chronological age at the start of the RSV season, can qualify based on criteria to the right. Diagnoses, conditions and risk factors must be clearly documented in the patient's medical record. Date of birth on or after 03/31/2007	<input type="checkbox"/> 29 To 32 Completed weeks gestational age: (Specify ICD-9 code) _____ OR <input type="checkbox"/> 32 to 35 Completed weeks gestational age: (Specify ICD-9 code) _____ WITH the following documented in the patient's medical record: <input type="checkbox"/> Severe neuromuscular disease (including chronic respiratory failure) OR <input type="checkbox"/> Significant congenital anomalies of the airway expected to compromise respiratory reserve: OR <input type="checkbox"/> 32 to 35 Completed weeks gestational age: (Specify ICD-9 code): _____ AND two of the following: <input type="checkbox"/> Direct exposure to tobacco smoke or other air pollution <input type="checkbox"/> Attends child care <input type="checkbox"/> Direct contact with siblings who attend school or child care		
Additional clinical information pertaining to medical necessity not otherwise provided above:			
Rx: <input type="checkbox"/> Synagis® (palivizumab) Liquid Solution 50mg and/or 100mg vials Sig: Inject 15mg/kg one time per month. Quantity: QS for weight based dosing			
<input type="checkbox"/> Syringes 1ml 25G 5/8"		<input type="checkbox"/> Syringes 3ml 20G 1"	
<input type="checkbox"/> Epinephrine 1:1000 amp. Sig: Inject 0.01mg/kg as directed		<input type="checkbox"/> Known Allergies: _____	
<input type="checkbox"/> Other: _____			
Sig: _____		Refills: _____	
Physician Name (printed) _____		Date _____	
Address _____			
City _____	State _____	ZIP _____	Phone _____ Fax _____
Physician Signature _____		Texas License No. _____	
Pharmacy Name _____		Phone _____ Fax _____	