

**TEXAS MEDICAID VENDOR DRUG PROGRAM FOR OUTPATIENT PHARMACIES
 SYNAGIS® (PALIVIZUMAB) PRIOR AUTHORIZATION REQUEST & PRESCRIPTION FORM for 2011**

Prescribing practitioner should fax completed form to the dispensing pharmacy

Pharmacy Name: _____ **Phone #** _____ **Fax #** _____

Patient Name: _____		Texas Medicaid Recipient Number: _____	
Date of Birth: _____	Telephone Number: _____		Telephone Number: _____
Address: _____		City: _____	State: _____
County of residence: _____			
Parent/Legal Guardian (if applicable): _____			
Age (in months) as of October 1st: _____ months		Estimated gestational age at birth: _____	
Current weight _____		completed weeks: _____ days	
<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 09/30/2009 (See Medicaid Bulletin NO. 199 November/December 2006 for details related to congenital heart and chronic lung disease diagnoses.)	<input type="checkbox"/> Active diagnosis of hemodynamically significant heart disease: (Specify ICD-9 Code(s)) _____ OR <input type="checkbox"/> Active diagnosis of Chronic Lung Disease of Infancy: (Specify ICD-9 Code(s)) _____ AND (applying to either\both of above) 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 <input type="checkbox"/> Routine\frequent use of bronchodilators *Chronic lung disease (CLDI) was formerly called bronchopulmonary dysplasia. It can develop in preterm neonates treated with oxygen and positive pressure ventilation. Many cases are seen in infants who previously had respiratory distress syndrome (RDS). CLDI is not asthma, croup, recurrent upper respiratory infections, chronic bronchitis, bronchiolitis, or a history of a previous RSV infection. OR <input type="checkbox"/> Solid organ or stem cell transplant recipient (Specify ICD-9 Code): _____		
<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 09/30/2010	<input type="checkbox"/> ≤ 28 6/7 weeks gestational age at birth (Specify ICD-9 Code): _____ OR <input type="checkbox"/> <35 weeks gestational age and severe neuromuscular disease (including chronic respiratory failure) (Specify ICD-9 Code): _____ OR <input type="checkbox"/> <35 weeks gestational age and significant congenital anomalies of the airway, expected to compromise ventilation (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 03/31/2011	<input type="checkbox"/> 29 through 31 6/7 weeks gestational age: (Specify ICD-9 code) _____ OR <input type="checkbox"/> 32 through 34 6/7 weeks gestational age: (Specify ICD-9 code): _____ AND two of the following: <input type="checkbox"/> Direct exposure to tobacco smoke or other documented environmental air pollutants. <input type="checkbox"/> Attends child care. <input type="checkbox"/> Siblings who attend school or child care. OR <input type="checkbox"/> Cystic Fibrosis (Specify ICD-9 Code): _____		
Current clinical information and diagnoses pertaining to medical necessity: (add additional page if necessary) _____ _____ _____			
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 Refills: _____ <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: _____ Physician Name (printed) _____ Date _____ Address _____ City _____ State _____ ZIP _____ Phone _____ Fax _____ Physician Signature _____ Texas License No. _____			

Dispensing Pharmacy should fax completed form to Texas Prior Authorization Center for approval: 1-866-617-8864