Reset Form Print Form

New Hampshire Medicaid Fee-for-Service Program
Prior Authorization Drug Approval Form

Synagis®

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

FIRST NAME:

MEDICAID ID NUMBER:

DATE OF BIRTH: – –

GENDER: ☐ Male ☐ Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

FIRST NAME:

SPECIALTY:

NPI NUMBER:

PHONE NUMBER: – –

FAX NUMBER: – –

SECTION III: CLINICAL HISTORY

1. Has the patient had a dose of Beyfortus™? ☐ Yes ☐ No
2. What is the patient's age? Provide patient's current age AND gestational age:

   Current age: _____ Gestational age: _____
3. Does the patient have a diagnosis of chronic lung disease and has the patient required medical therapy (i.e., supplemental oxygen, bronchodilator, diuretic, or corticosteroid therapy) within the six months before the start of RSV season? ☐ Yes ☐ No

   a. If *yes*, please list specific treatment and provide the date administered:

(Form continued on next page.)

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PATIENT LAST NAME:

PATIENT FIRST NAME:

SECTION III: CLINICAL HISTORY *(Continued)*

4. Has the patient been seen by any specialist who has recommended Synagis®? ☐ Yes ☐ No
   a. If *yes*, please provide type of specialist: _____
5. Does the patient have hemodynamically significant congenital heart disease AND any of the following? (Please check all that apply.) ☐ Yes ☐ No
   - ☐ Patient has moderate to severe pulmonary hypertension
   - ☐ Patient is receiving medications for CHF
   - ☐ Patient has acyanotic heart disease
   - ☐ Patient will require cardiac surgical procedures
6. Will the patient undergo cardiac transplantation during the RSV season? ☐ Yes ☐ No
7. Does the patient have a pulmonary abnormality or neuromuscular disease that impairs the ability to clear secretions from the upper airways? ☐ Yes ☐ No
8. Will the patient be profoundly immunocompromised during the RSV season? ☐ Yes ☐ No
9. Does the patient have cystic fibrosis and active lung disease? ☐ Yes ☐ No
10. Does the patient have any of the following conditions? (Please check all that apply.) ☐ Yes ☐ No
    - ☐ Secundum atrial septal defect
    - ☐ Small ventricular septal defect
    - ☐ Pulmonic stenosis
    - ☐ Uncomplicated aortic stenosis
    - ☐ Mild coarctation of the aorta
    - ☐ Patent ductus arteriosus
    - ☐ Mild cardiomyopathy not receiving therapy
    - ☐ Lesions corrected by surgery (unless w/CHF)
11. Please provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet:

_____

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

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