



**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:

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FIRST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

MEDICAID ID NUMBER:

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DATE OF BIRTH:

				-					-				
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GENDER:     Male     Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

**SECTION II: PRESCRIBER INFORMATION**

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

				-					-				
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FAX NUMBER:

				-					-				
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**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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DATE OF MEDICATION REQUEST:        /        /

**PATIENT LAST NAME:**

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**PATIENT FIRST NAME:**

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**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

- |  |  |
|--|--|
| <input type="checkbox"/> Secundum atrial septal defect             | <input type="checkbox"/> Small ventricular septal defect             |
| <input type="checkbox"/> Pulmonic stenosis                         | <input type="checkbox"/> Uncomplicated aortic stenosis               |
| <input type="checkbox"/> Mild coarctation of the aorta             | <input type="checkbox"/> Patent ductus arteriosus                    |
| <input type="checkbox"/> Mild cardiomyopathy not receiving therapy | <input type="checkbox"/> 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:** \_\_\_\_\_