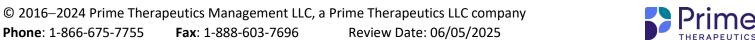


## **New Hampshire Medicaid Fee-for-Service Program Prior Authorization Drug Approval Form**

Synagis®  DATE OF MEDICATION REQUEST: /	1	
SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED		
AST NAME: FIRST NAME:		
MEDICAID ID NUMBER:	DATE OF BIRTH:	
GENDER: Male Female		
Orug Name: Strength:		
Dosing Directions:	Length of The	erapy:
SECTION II: PRESCRIBER INFORMATION		
AST NAME:	FIRST NAME:	
SPECIALTY:	NPI NUMBER:	
PHONE NUMBER:	FAX NUMBER:	
	-	
SECTION III: CLINICAL HISTORY		
L. Has the patient had a dose of Beyfortus™?		Yes No
<ol> <li>What is the patient's age? Provide patient's current ag</li> </ol>	re AND gestational age:	
<u> </u>	tional age:	
<ol> <li>Does the patient have a diagnosis of chronic lung disease and has the patient required medical Yes Note therapy (i.e., supplemental oxygen, bronchodilator, diuretic, or corticosteroid therapy) within</li> </ol>		
the six months before the start of RSV season?	,	
a. If yes, please list specific treatment and provide th	e date administered:	

(Form continued on next page.)







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

Synagis®

DATE OF MEDICATION REQUEST:	/ /	
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 significated following? (Please check all that apply.)	ant congenital heart disease AND any of the Yes No	
Patient has moderate to severe pulmonary h	nypertension 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?		
7. Does the patient have a pulmonary abnormality to clear secretions from the upper airways?	or neuromuscular disease that impairs the ability 🗌 Yes 📗 No	
8. Will the patient be profoundly immunocomprom	mised during the RSV season?	
9. Does the patient have cystic fibrosis and active lu	lung disease? Yes No	
10. Does the patient have any of the following conditions? (Please check all that apply.)		
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	myopathy not receiving therapy Lesions corrected by surgery (unless w/CHF)	
11. Please provide any additional information that w needed, please use a separate sheet:	would help in the decision-making process. If additional space is	
I certify that the information provided is accurate and complete to the best of my knowledge and I understand		
that any faisification, omission, or concealment of i	material fact may subject me to civil or criminal liability.	
PRESCRIBER'S SIGNATURE:	DATE:	

**Phone**: 1-866-675-7755 **Fax**: 1-888-603-7696

