Prior Authorization Form
Synagis®

Access this PA form at: https://optumrx.com/oe_tenncare/prescriber

If the following information is not complete, correct, or legible, the PA process can be delayed. Use one form per member please.

Member Information (required)			**Prescriber Information** (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	DEA#:	
Date of Birth:			Specialty:		
Street Address:			Office Phone:	Office Fax:	
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
			Is the prescriber a TennCare provider with a Medicaid ID? **Yes No** Is the prescriber a single-patient contract holder for this patient? **Yes No**		

****Note: The 2021-2022 RSV season has been extended through 10/31/2022 due to increased incidence of cases. For the 2022-2023 RSV season, Synagis® claims may ONLY be dispensed between the dates of 11/1/2022 and 4/30/2023 unless otherwise noted****

STRENGTH: ☐ 50 mg ☐ 100 mg **DIRECTIONS:** _____ **PATIENT WEIGHT:** _____

NAME OF DISPENSING PHARMACY: _____ **NPI NUMBER:** _____

Clinical Criteria Documentation *****Do **not** include documentation that is not requested on this form*****

1. **What is the patient's gestational age?** _____weeks _____days

2. **Does the patient have Chronic Lung Disease of Prematurity (formerly called Bronchopulmonary Dysplasia)?** ☐ Yes (go to 2a) ☐ No (go to 3)

   a. **Did the patient receive Oxygen immediately following birth?** ☐ Yes (go to 2b) ☐ No (go to question 3)

   b. **Please indicate the % oxygen received :** _____ **Duration of treatment:** _____

   c. **Please indicate if patient is receiving any of the following respiratory support therapies on a daily basis:**

   ☐ Oxygen Most recent date administered: _____

   ☐ Systemic corticosteroids Most recent date administered: _____

   ☐ Diuretics Most recent date administered: _____

3. **Does the patient have a diagnosis of Cystic Fibrosis?** ☐ Yes (go to question 3a) ☐ No (go to question 4)

   a. **Has the patient been hospitalized for a pulmonary exacerbation?** ☐ Yes (Date:_____) ☐ No

   b. **Does the patient have clinical evidence of chronic lung disease?** ☐ Yes ☐ No

   c. **Does the patient have clinical evidence of failure to thrive?** ☐ Yes ☐ No

   d. **Does the patient have pulmonary abnormalities on chest x-ray or CT that persist when the patient is stable?** ☐ Yes ☐ No

   e. **What is the patient's weight for length percentile?** _____

4. **Please indicate if patient has any of the following:**

☐ Anatomic pulmonary abnormality that impairs the ability to clear secretions, specify: _____

☐ Neuromuscular disorder that impairs the ability to clear secretions, specify: _____

☐ Congenital anomaly that impairs the ability to clear secretions, specify: _____

5. **Please indicate if patient has any of the**

☐ HIV ☐ Cancer, receiving chemotherapy ☐ Organ transplant receiving immunosuppressant therapy

☐ Other medical condition severely immunocompromising patient, specify: _____

6. **Has this patient received a heart transplant?** ☐ Yes (Date: _____) ☐ No

Prior Authorization Form
Synagis®

7. Does patient have hemodynamically significant congenital heart disease? ☐ Yes (please indicate) ☐ No

☐ With *acyanotic* heart defect (specify: _____)

☐ With *cyanotic* heart defect (specify: _____; Name of Pediatric Cardiologist:_____)

☐ Pulmonary Hypertension ☐ Other: _____

8. Is this patient a potential candidate for cardiac surgery due to a congenital heart defect? ☐ Yes ☐ No

9. Please list any medications that may be used:

☐ Ace-Inhibitor/ARB Most recent date administered: _____

☐ Diuretic Most recent date administered: _____

☐ Beta-blocker Most recent date administered: _____

☐ Digoxin Most recent date administered: _____

☐ Other cardiovascular medications (specify): _____

10. If this is a request for a sixth dose of Synagis during the RSV season, has the patient had an ECMO or cardiac bypass during the RSV season? ☐ Yes (Date: _____) ☐ No

Additional Documentation:

- *The pharmacy **shall** include the RSV Preventative Agents MAR (contained in Attachment A on page 3) hereto with the initial prescription and each subsequent refill of said prescription*
  - *Approved requests will be assigned specifically to the dispensing pharmacy.*

Please note any other information pertinent to this PA request:

_____

_____

_____

Prescriber Signature (Required) ***Date***

(By signature, the Physician confirms the above information is accurate and verifiable by patient records.)

Fax this form to: 1-866-434-5523
Phone: 1-866-434-5524
OptumRx will provide a response within 24 hours upon receipt.

TN Division of TennCare

Prior Authorization Form
Synagis®

Optum Rx®

Attachment A: TennCare Medication Administration Record (MAR)
Respiratory Syncytial Virus (RSV) Preventative Agents

(This form **must** be returned to the dispensing pharmacy after each administration of RSV Preventative Agent. No additional refills shall be dispensed without the previous MAR physically on file with the dispensing pharmacy)

Member Information

LAST NAME: **FIRST NAME:**

ID NUMBER: **DATE OF BIRTH:** – –

Prescriber Information

LAST NAME: **FIRST NAME:**

NPI NUMBER: **DEA NUMBER:**

CITY: **STATE:** **ZIP:**

SHIPPING ADDRESS:

E-MAIL ADDRESS:

CITY: **STATE:** **ZIP:**

PHONE NUMBER: – – **FAX NUMBER:** – –

This form MUST be returned to _____ Pharmacy at _____

(Name of Pharmacy) (Pharmacy Fax Number)

prior to additional fills.

Name of Drug Administered	Dosage Administered	Date of Administration	Name of Person Administering Drug (PRINT)	Signature of Person Administering Drug *(By signature the physician confirms the above information is accurate and verifiable by patient records.)*	Cred *(RN, LPN, MD, DO, etc.)*