

**TEXAS MEDICAID VENDOR DRUG PROGRAM
SYNAGIS® (PALIVIZUMAB) PRIOR AUTHORIZATION REQUEST & PRESCRIPTION FORM**

Patient's Name _____ Texas Medicaid Recipient Number _____
 Date of Birth _____ Gender: Male Female
 Address (Street) _____
 City _____ State _____ ZIP _____ Phone _____ Phone _____
 Parent/Legal Guardian Name (if applicable) _____

AGE IN MONTHS AT START OF RSV SEASON (AS OF OCTOBER 1 ST) _____	ESTIMATED GESTATIONAL AGE AT BIRTH: _____ COMPLETED WEEKS: _____ ICD-9 CODE: _____
---	---

<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 09/30/2005 (SEE MEDICAID BULLETIN #199 – Oct/Dec 2006 FOR DETAILS RELATED TO CONGENITAL HEART DISEASE DIAGNOSES.)	<input type="checkbox"/> HEMODYNAMICALLY SIGNIFICANT HEART DISEASE: (SPECIFY ICD-9 CODE(S)) _____ OR <input type="checkbox"/> CHRONIC LUNG DISEASE: (SPECIFY ICD-9 CODE(S)) _____ AND: REQUIRED ANY OF THE FOLLOWING THERAPIES WITHIN THE PAST 6 MONTHS <input type="checkbox"/> SUPPLEMENTAL OXYGEN <input type="checkbox"/> DIGITALIS <input type="checkbox"/> STEROIDS (systemic or inhaled) <input type="checkbox"/> DIURETICS <input type="checkbox"/> MECHANICAL VENTILATION *Chronic lung disease (CLD) was formerly called bronchopulmonary dysplasia. It can develop in pre term neonates treated with oxygen and positive pressure ventilation. Many cases are seen in infants who previously had respiratory distress syndrome (RSD). CLD is characterized by disordered lung growth and a reduction in the number of structures available for gas exchange. CLD is not asthma, croup, recurrent upper respiratory infections, chronic bronchitis, chronic bronchiolitis, or a history of a previous RSV infection.
---	---

<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 09/30/2006	<input type="checkbox"/> ≤ 28 COMPLETED WEEKS GESTATIONAL AGE AT BIRTH (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 03/31/2007	<input type="checkbox"/> 29 THROUGH 31 COMPLETED WEEKS GESTATIONAL AGE: (SPECIFY ICD-9 CODE) _____ OR <input type="checkbox"/> 32 TO 35 COMPLETED WEEKS GESTATIONAL AGE: (SPECIFY ICD-9 CODE) WITH THE FOLLOWING DOCUMENTED IN THE PATIENT'S MEDICAL RECORD: _____ WITH <input type="checkbox"/> SEVERE NEUROMUSCULAR DISEASE (INCLUDING CHRONIC RESPIRATORY FAILURE) OR <input type="checkbox"/> SIGNIFICANT CONGENITAL ANOMALIES OF THE AIRWAY EXPECTED TO COMPROMISE RESPIRATORY RESERVE: OR <input type="checkbox"/> 32 TO 35 COMPLETED WEEKS GESTATIONAL AGE: (SPECIFY ICD-9 CODE): _____ AND TWO OF THE FOLLOWING: <input type="checkbox"/> DIRECT EXPOSURE TO TOBACCO SMOKE OR OTHER AIR POLLUTION <input type="checkbox"/> ATTENDS CHILD CARE <input type="checkbox"/> DIRECT CONTACT WITH SIBLINGS WHO ATTEND SCHOOL OR CHILD CARE
---	--

ADDITIONAL CLINICAL INFORMATION PERTAINING TO MEDICAL NECESSITY NOT OTHERWISE PROVIDED ABOVE:

Rx: Synagis® (palivizumab) Liquid Solution 50mg and/or 100mg vials
Sig: Inject 15mg/kg one time per month. **Quantity:** QS for weight based dosing

Known Allergies: _____
 Other: _____

Sig: _____ **Refills:** _____

Physician Name (printed) _____ Date _____
 Address _____
 City _____ State _____ ZIP _____ Phone _____

Physician Signature _____ **Texas License No.** _____