Health First Colorado (Colorado's Medicaid Program)
Prior Authorization Request – Medical PAR
Synagis® Season 2016-2017
Fax: 1-866-940-4288 Phone: 1-888-801-9355

eq·Health solutions

Request Date: _____ This Request is for a
***(Check one)*: ☐ New PAR ☐ PAR Revision**

MEMBER INFORMATION

Member's Name: Last, First, Middle

_____

Colorado's Health First ID #: ☐☐☐☐☐☐☐

Date of Birth: ☐☐/☐☐/☐☐ Sex: ☐

Current Age: ☐☐ Years ☐☐ Months

Age at start of Synagis® Season: ☐☐ Years ☐☐ Months

Current Weight: ☐☐.☐ kg

Is the member receiving this service outside of Colorado? ☐ Yes ☐ No

If Yes, provide the location: _____

REQUESTOR'S INFORMATION

Name of person submitting this request: _____

Phone #: (☐☐☐) ☐☐☐-☐☐☐☐ Ext. ☐☐☐☐

Fax #: (☐☐☐) ☐☐☐-☐☐☐☐ email: _____

Request submitted on behalf of Medicaid Provider ID #: ☐☐☐☐☐☐☐☐

REQUESTING/ORDERING PROVIDER'S NAME

Requesting/Ordering Physician or Practitioner's Name:
(Last, First, Middle)

_____

Phone #: (☐☐☐) ☐☐☐-☐☐☐☐

Fax #: (☐☐☐) ☐☐☐-☐☐☐☐

Medicaid Provider ID #: ☐☐☐☐☐☐☐☐

BILLING PROVIDER'S INFORMATION

Billing Provider's Name: *(Last, First, Middle or Facility, if applicable.)*

_____

Phone #: (☐☐☐) ☐☐☐-☐☐☐☐

Fax #: (☐☐☐) ☐☐☐-☐☐☐☐

Medicaid Provider ID #: ☐☐☐☐☐☐☐☐

DIAGNOSIS AND DESCRIPTION INDICATING THE NEED FOR SYNAGIS® VACCINATION

ICD-10-CM Diagnosis Code(s)	Narrative Description(s)
1.	
2.	
3.	

SERVICES REQUESTED FOR CPT® CODE 90378

Service "From" Date	Service "Thru" Date	# Months Requested (1-5)	Units per Month	Total Units (mgs) for Requested timeframe (Months Requested X Units per Month)
☐☐/☐☐/☐☐	☐☐/☐☐/☐☐	☐	0 or 1: ☐ x 50 mg vials (NDC 60574-4114-1)	☐☐☐☐
☐☐/☐☐/☐☐	☐☐/☐☐/☐☐	☐	# of: ☐ x 100 mg vials (NDC 60574-4113-1)	☐☐☐☐

Health First Colorado (Colorado's Medicaid Program)
Prior Authorization Request – Medical PAR
Synagis® Season 2016-2017
Fax: 1-813-397-1783 Phone: 1-888-801-9355

eq·Health solutions

Member's Medicaid ID#: ☐☐☐☐☐☐☐☐☐☐

Member's Last/First/Middle Name: _____ Date of Birth: ☐☐/☐☐/☐☐

PLACE OF SERVICE	
Place of Service: *(Check one)*	☐ Physician or practitioner's office ☐ Hospital outpatient, e.g., emergency department ☐ Other (Explain): _____ ***NOTE:** If you are submitting this form for the administration of Synagis® in the home, DO NOT SUBMIT IT. Please follow the established process for LTHH prior authorization of LTHH RN visits for the sole purpose of administering Synagis®.*

CLINICAL INDICATIONS FOR SYNAGIS® VACCINATION

Check "Yes" for all that applies.	***Yes***	**Comments**
A. The member requires therapy outside of the approved age and diagnosis criteria. *If yes, explain in the "Comments" area. Clinical documentation may be attached if additional space is needed. Please check the following box if additional information is being submitted in addition to this request form.* ☐	☐	
B. The member has received at least one vaccine dose this Synagis® season. *If yes, explain in the "Comments" area and provide the following information:* *# Doses:* ☐ *Date of Last injection:* ☐☐/☐☐/☐☐	☐	
1. The member is in the first year of life at the start of the current RSV season or at the time of the 1st injection for the current season. In the first year of life Synagis® is recommended for: *(Check "Yes" for all that applies.)*		
A. Infants born before 29 weeks 0 days gestation	☐	
B. Infants born before 32 weeks 0 days **AND** with Chronic Lung Disease (CLD) of prematurity **AND** requirements of >21% oxygen for at least 28 days after birth.	☐	
C. Infants with hemodynamically significant heart disease (acyanotic heart disease who are receiving medication to control CHF and will require cardiac surgical procedures **AND** infants with moderate to severe pulmonary hypertension) **AND** born within 12 months of onset of the RSV season.	☐	
D. Children who undergo cardiac transplantation during the RSV season.	☐	
E. Infants with cyanotic heart defects **AND** in consultation with a pediatric cardiologist **AND** requirements of >21% oxygen for at least 28 days after birth **AND** continues to require medical intervention (supplemental oxygen, chronic corticosteroid, or diuretic therapy).	☐	
F. Infants with neuromuscular disease or pulmonary abnormality **AND** an inability to clear secretions from the upper airways.	☐	
G. Children who will be profoundly immunocompromised during the RSV season (solid organ or hematopoietic stem cell transplantation, receiving chemotherapy).	☐	
H. Infants with cystic fibrosis with clinical evidence of CLD **AND/OR** nutritional compromise	☐	

Member's Medicaid ID#: ☐☐☐☐☐☐☐

Member's Last/First/Middle Name: _____ Date of Birth: ☐☐/☐☐/☐☐

CLINICAL INDICATIONS FOR SYNAGIS® VACCINATION, Continued

2. The member is in the second year of life. In the second year of life Synagis® is recommended for:

Check "Yes" for all that applies.	***Yes***	**Comments**
A. Infants born before 32 weeks 0 days **AND** with CLD of prematurity **AND** requirements of >21% oxygen for at least 28 days after birth **AND** continue to require medical intervention (supplemental oxygen, chronic corticosteroid, or diuretic therapy).	☐	
B. Children who will be profoundly immunocompromised during the RSV season (solid organ or hematopoietic stem cell transplantation, receiving chemotherapy).	☐	
C. Infants with manifestations of severe lung disease (previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities of chest radiography or chest computed tomography that persist when stable) **OR** weight for length less than the 10th percentile.	☐	
C. Children who undergo cardiac transplantation during the RSV season.	☐	

ADDITIONAL COMMENTS: