SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Prior Authorization Request Form

Universal Synagis®

Form must be complete, correct, and legible or the PA process can be delayed.
Use one form per member, please.

Request Date: ____ / ____ / _____

***Fax the COMPLETED form or call the plan with the requested information.**

Absolute Total Care	FFS Medicaid	First Choice	Healthy Blue by Blue Choice of SC	Humana Healthy Horizons of SC	Molina Healthcare
P: 866-433-6041 F: 855-865-9469	P: 866-247-1181 F: 888-603-7696	P: 866-610-2773 F: 866-610-2775	P: 833-988-1264 F: 844-512-7027	P: 866-432-0001 F: 877-486-2621	P: 855-237-6178 F: 855-571-3011

I. MEMBER INFORMATION

First Name | **Last Name**

Medicaid ID # | **Date of Birth (MM/DD/YYYY)** / / | **Sex** ☐ Male ☐ Female

II. PRESCRIBER INFORMATION

Prescriber's First Name | **Prescriber's Last Name**

National Provider ID # (NPI) | **DEA Number**

Prescriber's Phone Number - - | **Prescriber's Fax Number** - -

III. PHARMACY INFORMATION

Name of Dispensing Pharmacy | **NPI #**

Pharmacy Phone Number - - | **Pharmacy Fax Number** - -

IV. DRUG INFORMATION

Strength: ☐ **50 mg (NDC 60574-4114-01)** **Quantity:** _____ **PA Start Date:** _____

☐ **100 mg (NDC 60574-4113-01)** **Quantity:** _____ **PA Start Date:** _____

V. CLINICAL CRITERIA DOCUMENTATION *(**Do NOT include documentation that is not requested on this form**)*

1. **What was the patient's gestational age at birth?**

   _____ weeks _____ days **ICD Diagnosis Code:** _____

2. **What is the patient's current weight?**

   _____ kg **OR** _____ lb

3. **Does the patient have Chronic Lung Disease of Prematurity (formerly called bronchopulmonary dysplasia)?**

   ☐ Yes (go to question 4) ☐ No (go to question 6)

4. **Did the patient receive oxygen immediately following birth?**

   ☐ Yes (go to question 5) ☐ No (go to question 6)

5. **Indicate the % oxygen received, date received, and the duration of treatment**: _____

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6. Indicate if patient is receiving any of the following respiratory support therapies on a daily basis:

- ☐ Systemic corticosteroids — Most recent date: _____
- ☐ Diuretics — Most recent date: _____
- ☐ Bronchodilator — Most recent date: _____
- ☐ Oxygen — Most recent date: _____

7. Does the patient have a diagnosis of Cystic Fibrosis?

- ☐ Yes — If yes, submit documentation of pulmonary and nutritional status
- ☐ No

8. Does the patient have any of the following?

- ☐ Anatomic Pulmonary Abnormality. Please specify: _____
- ☐ Neuromuscular Disorder. Please specify: _____

9. Does the patient have any of the following?

- ☐ HIV
- ☐ Cancer, receiving chemotherapy
- ☐ Organ transplant, receiving immunosuppressant therapy
- ☐ Other medical condition that is severely immunocompromising patient (e.g., Children younger than 24 months who will be profoundly immunocompromised during the RSV season).

  Please specify: _____

10. Has this patient received a heart transplant?

- ☐ Yes — Date: _____
- ☐ No

11. Does patient have hemodynamically significant congenital heart disease?

- ☐ Yes — Please indicate: _____
- ☐ No
- ☐ Acyanotic heart disease — Most recent date: _____
- ☐ Cyanotic heart disease — Specify: _____ Name of Pediatric Cardiologist: _____
- ☐ Pulmonary Hypertension
- ☐ Other: _____

12. Will this patient's congenital heart disease require cardiac surgery?

- ☐ Yes
- ☐ No

13. 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. Please specify: _____

14. Please note any other information pertinent to this PA request:

_____

_____

_____

_____ _____

Prescriber Signature (Required) **Date**

(**On behalf of the Prescriber or Pharmacy Provider, I certify that the information stated above is a true statement, made for the purposes of inducing SC Medicaid to offer prescription coverage to this individual for the medication requested above. I understand that this document and any attached materials will be retained for the purposes of possible future audit).