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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	Molina Healthcare	WellCare Health Plan
P: 866-433-6041 F: 855-865-9469	P: 866-247-1181 F: 888-603-7696	P: 866-610-2273 F: 866-610-2775	P: 866-902-1689 F: 800-823-5520	P: 855-237-6178 F: 855-571-3011	P: 888-588-9842 F: 866-354-8709

I. MEMBER INFORMATION

First Name

Last Name

Medicaid ID #

Date of Birth (MM/DD/YYYY) ___ / ___ / ____

Sex ☐ **Male** ☐ **Female**

II. PRESCRIBER'S 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)

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

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).