**Note**: Processing may be delayed if information submitted is illegible or incomplete.

# ENROLLEE INFORMATION

**Enrollee’s Last Name: Enrollee’s First Name:**

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**Date of Birth: Enrollee’s Medicaid ID (2 letters, 5 numbers, 1 letter):**

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**Gender:** MaleFemale

**Gestational Age:** \_\_\_\_\_\_\_\_\_\_ Weeks \_\_\_\_\_\_\_\_\_\_ Days

**Current Weight:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# PRESCRIBER INFORMATION

**Prescriber’s Last Name: Prescriber’s First Name:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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**Contact Person:**

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**National Provider Identifier (NPI) Number:**

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**Office Phone Number: Office Fax Number:**

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# DRUG INFORMATION

**Drug Name:** Synagis® (palivizumab)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Strength:**  50 mg/0.5 mL  100 mg/1 mL

**Directions:** Inject 15 mg/kg IM once monthly\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Refills (5-dose quantity limit):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Form continued on next page.)*

**Enrollee’s Last Name: Enrollee’s First Name:**

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# Clinical Criteria

## Section A: For patients < 12 months of age at RSV season onset (October 16):

1. Is patient < 12 months of age at the onset of the current RSV season (October 16)?

Yes  No

If **YES**, continue with questions 2-5 below (Section A).

If **NO**, please move to section B.

2. Was patient born at gestational age less than 29 weeks?

Yes  No

3. Does the patient:

* Have Chronic Lung Disease (CLD) of prematurity (formerly called Bronchopulmonary Dysplasia); **AND**
* Gestational age less than 32 weeks; **AND**
* Require > 21% oxygen use for ≥ 28 days post-birth?

Yes  No

1. Does the patient have a congenital airway abnormality or neuromuscular disorder that decreases the ability to manage airway secretion?

Yes  No

1. Does the patient have hemodynamically significant heart disease (examples below)?

* Infant with acyanotic heart disease receiving medication to control congestive heart failure and will require cardiac surgery; **OR**
* Infant with moderate to severe pulmonary hypertension; **OR**
* Potentially, infant with cyanotic heart disease, with consultation by cardiologist

Yes  No

*(Form continued on next page.)*

**Enrollee’s Last Name: Enrollee’s First Name:**

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# Clinical Criteria (*continued*)

## Section B: For patients < 24 months of age at RSV season onset (October 16):

1. Does the patient:

* Have Chronic Lung Disease of prematurity; **AND**
* Require medical support (i.e., oxygen, bronchodilator, diuretic, chronic steroid therapy) within 6 months prior to second RSV season onset?

Yes  No

1. Does the patient require a solid-organ transplant during the current RSV season?

Yes  No

1. Is patient profoundly immunocompromised during RSV season?

Yes  No

1. If **YES**, please provide additional information on cause of immunocompromised state:

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1. Please provide any additional information that should be considered:

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| --- | --- | --- |
| Prescriber Signature (Required)  *I attest that Synagis® is medically necessary for this patient and that all of the information on this form is accurate to the best of my knowledge. I attest that documentation of the above diagnosis and medical necessity is available for review if requested by New York Medicaid.* |  | Date |

**Fax Number:** 1-800-268-2990

**Prior Authorization Call Line:** 1-877-309-9493

**Billing Questions:** 1-800-343-9000

For clinical questions or Clinical Drug Review Program questions, please visit <http://newyork.fhsc.com> or call 1-877-309-9493.