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aetna™

Aetna Better Health® of Florida (MEDICAID)

Prior Authorization

SYNAGIS® – All Florida Regions Combined

Coverage Period: Based upon the specific region per the FLDOH website:
http://www.floridahealth.gov/diseases-and-conditions/respiratory-syncytial-virus/
Maximum number of doses: 5
Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID#

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

Recipient's Full Name

Prescriber's Full Name

Prescriber's NPI

Prescriber Phone Number ___ - ___ - ____

Prescriber Fax Number ___ - ___ - ____

Synagis Vial Qty:
SIG: Inject 15 mg/kg IM once monthly

☐ 100 mg ☐ 50 mg

Start Date: _____

Refill(s): _____mos

Birth Weight: _____ ☐ lbs / ☐ kgs

Current Weight: _____ ☐ lbs / ☐ kgs

Gestational Age (GA) : _____

☐ If < 24 months old

☐ Cardiac transplant during RSV season

☐ Already on prophylaxis and eligible; give post-op dose after cardiac bypass or after ECMO

☐ Profoundly Immunocompromised (Specify Diagnosis Code)_____

☐ If > 12 months old and < 24 months old

☐ Cystic Fibrosis

AND: must meet at least one of the following criteria

- ☐ Nutritional compromise (weight for length < 10th percentile)
- ☐ Hospitalization for pulmonary exacerbation in first year of life
- ☐ Chest X-ray or CT abnormalities that persist when stable

☐ Chronic lung disease (GA < 32 weeks and required oxygen for at least first 28 days after birth)

(Specify Diagnosis Code) _____

AND: has required any of the following therapies within the past 6 months:

- ☐ Supplemental oxygen
- ☐ Steroids (systemic or inhaled)
- ☐ Mechanical ventilation
- ☐ Diuretics

*CLD is not asthma, croup, recurrent upper respiratory infections, chronic bronchitis, chronic bronchiolitis, or a history of a previous RSV infection.

Fax completed prior authorization request form to Aetna Better Health of Florida at 855-799-2554 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

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☐ If ≤ 12 months old

☐ Hemodynamically significant cyanotic or acyanotic congenital heart disease on medications to control CHF and will require surgery:

(Specify Diagnosis Code) _____

☐ Moderate to severe pulmonary hypertension

☐ If < 12 months old

☐ < 29 completed weeks gestational age at birth (otherwise healthy)

Diagnosis Code: ICD 10: P07.21 – P07.26

☐ Chronic lung disease* (GA < 32 weeks): (Specify Diagnosis Code) _____

☐ **AND:** required supplemental oxygen (for at least first 28 days after birth)

*CLD is not asthma, croup, recurrent upper respiratory infections, chronic bronchitis, chronic bronchiolitis, or a history of a previous RSV infection.

☐ Severe neuromuscular disease

(Specify Diagnosis code) _____

☐ Congenital anomalies of the airways

(Specify Diagnosis code) _____

☐ Profoundly immunocompromised

(Specify Diagnosis code)_____

☐ Cystic Fibrosis with CLD and/or nutritional compromise

Prescriber's Signature: _____ **Date:** _____

REQUIRED FOR REVIEW: Copies of medical records (e.g., diagnostic evaluations and recent chart notes), the most recent copies of related labs, and supporting documentation for clinically appropriate submissions.

The provider must retain copies of all documentation for five years.

NOTE: Pharmacies should not submit separate claims for different dosage strength vials to be administered on the same date. Only one compound claim submission will be necessary. For example, if the Synagis dosage is 150 mg, the pharmacy should submit a compound claim that lists the two different strength vials (100 mg and 50 mg).

Weight Criteria for Synagis® (palivizumab): (Refer to *Weight Change Form*)

All weights must be verified for dosing accuracy.

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