*Texas Standard Prior Authorization Form Addendum*

# Molina Healthcare of Texas
## Synagis (palivizumab) (Medicaid)

This fax machine is located in a secure location as required by HIPAA Regulations. Complete / Review information, sign, and date. Fax signed forms to Molina Pharmacy Prior Authorization Department at **1-888-487-9251**. Please contact Molina Pharmacy Prior Authorization Department at **1-855-322-4080** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Synagis (Medicaid).

| Drug Name (select from list of drugs shown / provide drug information) | |
|---|---|
| SYNAGIS 50 MG/0.5 ML VIAL | SYNAGIS 100 MG/1 ML VIAL |

| Patient Information | |
|---|---|
| Patient Name: | |
| Patient ID: | |
| Patient DOB: | |

| Prescribing Physician | |
|---|---|
| Physician Name: | |
| Physician Phone: | |
| Physician Fax: | |
| Physician Address: | |
| City, State, Zip: | |

| | |
|---|---|
| Diagnosis: | ICD Code: |
| Directions for administration: | |
| Member's Current Weight: | |

*****Please include all relevant clinical notes, lab work, medication history and any other applicable documentation.**
**Please check the preferred status of the requested drug as not all questions may apply.**

Please circle the appropriate answer for each question.

1. Is the requested drug required per court order? (court order required) Y N
   *If the answer to this question is yes, approved for 10 days.*
   *If the answer to this question is no, go to question 2.*

2. Is this request for continuation of therapy? Y N
   *If the answer to this question is yes, go to question 25.*
   *If the answer to this question is no, go to question 3.*

3. Has the prescriber indicated the patient's weight? Y N
   *If the answer to this question is yes, go to question 4.*
   *If the answer to this question is no, denied.*

4. Is the patient's chronological age less than 12 months at the beginning of the RSV season for the patient's county of residence? Y N
   *If the answer to this question is yes, go to question 5.*

*If the answer to this question is no, go to question 15.*

5. Is the patient's gestational age less than or equal to 28 6/7 weeks? Y N
   *If the answer to this question is yes, go to question 23.*
   *If the answer to this question is no, go to question 6.*

6. Does the patient have a diagnosis of chronic lung disease (CLD) of prematurity? Y N
   *If the answer to this question is yes, go to question 7.*
   *If the answer to this question is no, go to question 8.*

7. Is the patient's gestational age less than or equal to 31 6/7 weeks? Y N
   *If the answer to this question is yes, go to question 23.*
   *If the answer to this question is no, go to question 8.*

8. Does the patient have a severe congenital abnormality of the airway? Y N
   *If the answer to this question is yes, go to question 23.*
   *If the answer to this question is no, go to question 9.*

9. Does the patient have a diagnosis of severe neuromuscular disease that compromises the handling of respiratory tract secretions? Y N
   *If the answer to this question is yes, go to question 23.*
   *If the answer to this question is no, go to question 10.*

10. Does the patient have a diagnosis of acyanotic heart disease? Y N
    *If the answer to this question is yes, go to question 11.*
    *If the answer to this question is no, go to question 12.*

11. Does the patient have 1 claim for a medication for heart failure in the last 60 days, AND will require cardiac surgery? Y N
    *If the answer to this question is yes, go to question 23.*
    *If the answer to this question is no, go to question 12.*

12. Does the patient have a diagnosis of moderate to severe pulmonary hypertension? Y N
    *If the answer to this question is yes, go to question 23.*
    *If the answer to this question is no, go to question 13.*

13. Does the patient have a diagnosis of cyanotic heart disease? Y N
    *If the answer to this question is yes, go to question 23.*
    *If the answer to this question is no, go to question 14.*

14. Does the patient have a diagnosis of cystic fibrosis (CF) with clinical evidence of CLD and/or nutritional compromise? Y N
    *If the answer to this question is yes, go to question 23.*
    *If the answer to this question is no, go to question 15.*

15. Is the patient less than 24 months of age at the beginning of the RSV season for the patient's county of residence? Y N
    *If the answer to this question is yes, go to question 16.*
    *If the answer to this question is no, denied.*

16. Does the patient have a diagnosis of an identified disease state that will leave them profoundly immunocompromised during the RSV season? Y N
    *If the answer to this question is yes, go to question 23.*
    *If the answer to this question is no, go to question 17.*

17. Has the patient had a solid organ or hematopoietic stem cell transplant during the RSV season? Y N
    *If the answer to this question is yes, go to question 23.*
    *If the answer to this question is no, go to question 18.*

18. Is the patient less than 24 months chronological age and greater than or equal to 12 months chronological age at the beginning of the RSV season for the patient's county of residence? Y N
*If the answer to this question is yes, go to question 19.*
*If the answer to this question is no, denied.*

19. Does the patient have a diagnosis of chronic lung disease (CLD) of prematurity? Y N
*If the answer to this question is yes, go to question 20.*
*If the answer to this question is no, go to question 22.*

20. Is the patient's gestational age less than or equal to 31 6/7 weeks? Y N
*If the answer to this question is yes, go to question 21.*
*If the answer to this question is no, go to question 22.*

21. Does the patient have a history of any of the following in the last 180 days: chronic use of systemic corticosteroids, diuretics, long-term mechanical ventilator, and/or supplemental oxygen? Y N
*If the answer to this question is yes, go to question 23.*
*If the answer to this question is no, go to question 22.*

22. Does the patient have a diagnosis of cystic fibrosis (CF) with severe lung disease OR weight less than the 10th percentile? Y N
*If the answer to this question is yes, go to question 23.*
*If the answer to this question is no, denied.*

23. Is the claim for 1 vial of either the 50mg or 100mg vials? Y N
*If the answer to this question is yes, go to question 24.*
*If the answer to this question is no, denied.*

24. Are there greater than 4 dates of service for palivizumab since the beginning of the current RSV season (determined by patient's county of residence) until today? Y N
*If the answer to this question is yes, denied.*
*If the answer to this question is no, go to question 30.*

25. Has the patient been hospitalized for RSV since the last palivizumab dose? Y N
*If the answer to this question is yes, denied.*
*If the answer to this question is no, go to question 26.*

26. Has the pharmacy indicated the patient's weight? Y N
*If the answer to this question is yes, go to question 27.*
*If the answer to this question is no, denied.*

27. Did the pharmacy indicate date of last palivizumab dose? Y N
*If the answer to this question is yes, go to question 28.*
*If the answer to this question is no, denied.*

28. Are there greater than 4 dates of service for palivizumab since the beginning of the current RSV season (determined by patient's county of residence) until today? Y N
*If the answer to this question is yes, denied.*
*If the answer to this question is no, go to question 29.*

29. Is the claim for 1 vial of either the 50mg or 100mg vials? Y N
*If the answer to this question is yes, go to question 30.*
*If the answer to this question is no, denied.*

30. Is this request for a non-preferred drug? Y N
*If the answer to this question is yes, go to question 31.*
*If the answer to this question is no, approved for 10 days.*

31. Has the patient failed a treatment trial with at least 1 preferred agent? Y N

*If the answer to this question is yes, approved for 10 days.*
*If the answer to this question is no, go to question 32.*

32. Is there a documented allergy or contraindication to preferred agents in this class? Y N
*If the answer to this question is yes, approved for 10 days.*
*If the answer to this question is no, go to question 33.*

33. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? Y N
*If the answer to this question is yes, approved for 10 days.*
*If the answer to this question is no, denied.*

Comments:

*I affirm that the information given on this form is true and accurate as of this date.*

_____ _____
Prescriber (or Authorized) Signature Date