Michigan Medicaid

Department of Health and Human Services

Prescription Drug Prior Authorization Form: Synagis®

Fax this form to 888-603-7696

All information on this form must be addressed. Incomplete forms will be returned only once for missing information. Mark as "N/A" if no information is available or does not apply. Issues that remain blank after being returned once will receive a denial and will not qualify for MDHHS physician review until completed or clearly marked "N/A."

BENEFICIARY INFORMATION

Beneficiary Last Name: ______________________

Beneficiary First Name: ______________________

Medicaid ID: ______________________ Date of Birth: ______________________

Sex: ☐ Male ☐ Female

PRESCRIBER INFORMATION

Prescriber Last Name: ______________________

Prescriber First Name: ______________________

Prescriber Credentials (Select One): ☐ MD ☐ PA ☐ NP ☐ DO ☐ Other: ______________

Specialty: ______________________

Prescriber NPI: ______________________ DEA: ______________________

Prescriber Phone: ______________________ Prescriber Fax: ______________________

PERSON COMPLETING FORM

Person Last Name: ______________________

Person First Name: ______________________

Person Title: ______________________ Date: ______________

Person Phone Number: ______________ Person Fax Number: ______________

Requested Start Date: ______________

PHARMACY INFORMATION

Pharmacy Name: ______________________

Pharmacy Phone Number: ______________ Pharmacy Fax Number: ______________

DRUG INFORMATION

Drug Name: **Synagis** Requested Start Date: ______________

Drug Strength:

☐ 50 mg ☐ 100 mg

Duration of Prescription: **October 1 through April 30**

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Member's Name (Last, First): ______________________________

CLINICAL INFORMATION

Patient Weight in Kilograms:______________ Gestational Age: ______________

Check applicable age and condition:

☐ Children who have not had a dose of Beyfortus™ (nirsevimab) in the current RSV season.

☐ Mother did not receive vaccination against RSV in the 2nd or 3rd trimester.

☐ Children < 12 months of age on October 1st of the current season and born < 29 weeks gestational age.

☐ Children < 12 months of age on October 1st of the current season with chronic lung disease (CLD) of prematurity, defined as < 32 weeks gestational age, and requiring > 21% oxygen for at least 28 days after birth.

- Percentage of oxygen required: ________ Duration of treatment: ____________________

☐ Children < 24 months of age on October 1st of the current season with a history of chronic lung disease of prematurity (defined above) and who continued to receive medical treatment such as oxygen, chronic corticosteroids, or diuretic medications during the previous six months.

Percent of Oxygen Required: ______________ Date of Last Use: ______________

Duration of Treatment: ______________________________

Corticosteroid(s) Prescribed: ______________ Date of Last Use: ______________

Diuretic(s) Prescribed: ______________ Date of Last Use: ______________

☐ Children < 12 months of age on October 1st of the current season with hemodynamically significant cyanotic or acyanotic congenital heart disease.

- Children receiving medication to control congenital heart failure who will require cardiac surgery.
- Children with moderate to severe pulmonary hypertension
- Children with cyanotic heart disease

☐ Children < 12 months of age on October 1st of the current season, with pulmonary abnormalities or neuromuscular disease that affects the ability to clear secretions.

☐ Children < 24 months of age on October 1st of the current season, who are severely immunocompromised (e.g., receiving chemotherapy) during RSV season.

If none of the listed conditions apply, provide details including age, gestational age, and any risk factors or conditions:

☐ Attachments

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group, or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber's Signature: ______________________________**Date:**______________

(By signature, the physician confirms the above information is accurate and verifiable by patient records.)

(Form continued on next page)

Member's Name (Last, First): ______________________________

Mail requests to:
Magellan Medicaid Administration
11013 W Broad Street
Suite 500
Glen Allen, VA 23060
Phone: (877) 864-9014

This form is available at https://michigan.magellanrx.com/provider/forms.

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