AmeriHealth Caritas
New Hampshire

Synagis®
Prior Authorization Drug Approval Form

Date of medication request: (MM/DD/YYYY): ____ / ____ / ______

Patient information and medication requested	
Patient's name:	Medicaid number:
Date of birth:	Gender:
Drug name:	Strength:
Dosing directions:	Length of therapy:

Prescriber information		
Prescriber last name:		Prescriber first name:
Prescriber address:		Prescriber representative:
Specialty:		NPI number:
Phone #:	Fax #:	

Clinical history

1. What is the patient's age? (provide patient's current age AND gestational age) ☐ Yes ☐ No

2. Does the patient have a diagnosis of chronic lung disease and has required medical therapy (i.e., supplemental oxygen, bronchodilator, diuretic, or corticosteroid therapy) within the six months before the start of RSV season? ☐ Yes ☐ No
Please list specific treatment and provide the date administered:?

3. Does the patient have any of the following risk factors? (please check all that apply) ☐ Yes ☐ No
☐ Child care attendance
☐ Exposure to environmental pollutants
☐ Severe neuromuscular disease
☐ Long distance from hospital care
☐ School-aged siblings
☐ Congenital abnormalities of the airways
☐ Low birth weight

4. Does the patient have a diagnosis of hemodynamically significant cyanotic or acyanotic congenital heart disease? ☐ Yes ☐ No

5. Does the patient have congenital heart disease AND one of the following? (please check all that apply) ☐ Yes ☐ No
☐ Moderate to severe pulmonary hypertension
☐ Cyanotic heart disease
☐ Receiving medications for CHF

6. Does the patient have any of the following conditions? (please check all that apply) ☐ Yes ☐ No
☐ Secundum atrial septal defect
☐ Pulmonic stenosis
☐ Mild coarctation of the aorta
☐ Mild cardiomyopathy not receiving therapy
☐ Small ventricular septal defect
☐ Uncomplicated aortic stenosis
☐ Patent ductus arteriosus
☐ Lesions corrected by surgery (unless w/CHF)

Provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

Signature of prescriber:______________________________ Date: ______________
(prescriber signature mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

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