Maryland Medicaid Pharmacy Program (MMPP)
SYNAGIS SERVICE PRIOR-AUTHORIZATION
(Incomplete forms will be returned)
Fax #: 1-866-440-9345

Participant and Insurance Information

Participant Name:_____________________________ **Participant DOB:**_______________ **Medicaid ID#:**_______________
(Last, MI, First) (MM/DD/YYYY)

MCO Patient? □ Yes □ No **Date of Service:**_______________

Date of Scheduled Drug Injection: _______________ **Location:** □ Office □ Clinic

Once prior-authorization (PA) has been issued for the **requested specific date of service, the approved quantity and the approved days supply**, providers must resubmit the claim using these **exact** data elements. Changing any of these data elements will result in a reject claim. Do not use different dates when referring to the same shipment (i.e. when date of service could refer to either the billing date or shipping date, such date must be consistent with provider's record keeping).

Third Party Liability - List Other Insurance:____

Note: Maryland Medicaid is always the payer of last resort. List units dispensed and payment made by other insurance for coordination of benefits:

NDC 60574-4114-01(50mg/0.5ml vial) - **Quantity billed =**_____ **Other insurance paid: $**________
NDC 60574-4113-01(100mg/1ml vial) - **Quantity billed =**_____ **Other insurance paid: $**________

Refer to back of form for instructions on determination of number of Synagis vials to ship.

Required Documentation of Patient's Weight History

Documentation of a minimum of 3 prior actual weight measurements is required for the processing of each Service PA.

Date of Weight Measurement	Actual Weight As Documented in Medical Record
	□ Kg.
	□ Kg.
	□ Kg.
	□ Kg.

Any experience with breakthrough RSV and/or any hospitalization during the RSV season? □ Yes □ No
Specify Date: ______________

I certify to the validity of the patient's weight data as submitted. Supporting medical documentation is available in the patient's medical record for the weights based on which the doses were calculated.

____ **Date:** _______________
Name of Medical Staff (CRNP, or RN, or MD)

Medical Staff's Phone #:_______________________ **Medical Staff's Fax #:**_________________________

This Service Prior-Auth Request will not be processed if not signed by a medical staff.
(Signatures cannot be from the dispensing pharmacy staff).

Pharmacy Name where Rx will be filled:_________________________________ **Pharmacy Phone #:**_____________________

Pharmacy Contact Person:______________________________ **Pharmacy Fax #:** _______________________

MDH091021

FOR INTERNAL USE

Approved from:____/____/____to _____/____/____ **Reviewer's Initials: ________________**

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WORKSHEET FOR DETERMINING THE NUMBER OF REQUIRED SYNAGIS VIALS

A = Participant's actual weight used for calculating last month's injection**:____________ kg.**

Weight Measured on Date:_______________

B = Calculated average weight gain *****per month**:________ kg/month**
(Difference between the last two consecutive weight measurements x 28 days = days intervals between the two measurements)

Weight measurement # 1:________ kg. **Taken on:______________**

Weight measurement # 2:________ kg. **Taken on:______________**

* **Average weight gain =** Weight measurement # **2** minus Weight measurement #**1**, assuming the patient did not lose weight (some infants or children may lose weight due to illness or hospitalizations).

Ex: If the days interval between the two measurements is 19 days between the two weight measurements, then prorate per 28 days) **= Weight measurement #2 – Weight measurement #1 x 28 days: 19 days**

C = Estimated weight to be used in dosing this month's injection: Add the average weight gain per month **(B)** to the previous month's weight measurement **(A): C = A + B**

Estimated dose needed for this month's injection + 15mg x Estimated Weight **(C) (kg)**

Number of vials to bill and ship: **Refer to the Synagis Dose Chart.**

NOTE:

- If the Synagis dose falls within a certain range, it will be rounded up or down to the closest whole vial size. The maximum dose reduction due to this rounding down of the estimated dose is 5%. This will reduce wastage of expensive medication, while still providing effective protection against RSV.
- Service Prior-auth for Synagis will be granted within 24 hours between Oct 23rd throughout Mar 31st of the RSV season The prescriber and/or nursing staff must complete and fax the Service PA request form to their specialty pharmacy each month to request a shipment of Synagis once the patient has been approved for Synagis for the entire RSV season.