Clear Form

DEPARTMENT OF HUMAN SERVICES

DHS-6428-ENG 10-20

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

Synagis® Authorization Form

Use this form to request authorization for Synagis®. **Incomplete forms will be returned. Submit form with documentation, such as relevant chart notes.**

Health Information Designs, LLC
PO Box 3210
Auburn AL 36832-3210
Phone: 866-205-2818 Fax: 866-648-4574

Requestor information

REQUESTOR NAME	PHONE NUMBER	REQUESTOR AFFILIATION (check one)
		◯ Pharmacy ◯ Prescriber

Member information

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	MHCP ID NUMBER

Administering provider information

PROVIDER NAME		NATIONAL PROVIDER IDENTIFIER (NPI)
CONTACT NAME	PHONE NUMBER	FAX NUMBER

Prescribing provider information

PROVIDER NAME		NPI
CONTACT NAME	PHONE NUMBER	FAX NUMBER

Medication, Clinical and Billing information

DRUG AND DOSE REQUESTED	HCPCS CODE	CURRENT WEIGHT IN KGS	GESTATIONAL AGE
		_____ as of _____	_____ weeks _____ days
ICD DIAGNOSIS CODE			REQUESTED START DATE

Synagis® (palivizumab) is a physician-administered drug. Administering providers or facilities must bill MHCP directly using the appropriate HCPCS code (buy and bill) for drugs administered in a clinic or other outpatient setting. A pharmacy cannot bill for Palivizumab using a National Drug Code (NDC).

(Continue to next page to complete criteria information.)

Check applicable criteria and submit supporting documentation

(discharge summary from birth, pulmonology report, cardiology report, chart notes, etc.)

- ☐ Gestational age ≤ 28 weeks 6 days and ≤ 12 months of age
- ☐ Infant or child ≤ 12 months of age, as of November 2, 2020, with a diagnosis of one or more of the following that impacts pulmonary function: Interstitial Lung Disease (ILD), neuromuscular condition, or a congenital airway abnormality
- ☐ Gestational age < 32 weeks and < 24 months of age with a diagnosis of Chronic Lung Disease (CLD) of prematurity or Bronchopulmonary Dysplasia (BPD) having required one of the following in the past 6 months:
  - ☐ Supplemental O2
  - ☐ Recent use of corticosteroid therapy
  - ☐ Regular or intermittent use of diuretics
- ☐ < 12 months of age, as of November 2, 2020, with a diagnosis of hemodynamically significant heart disease or congenital heart disease, having one or more of the following:
  - ☐ Currently receiving medication to control congestive heart failure
  - ☐ Moderate to severe pulmonary hypertension
  - ☐ Cyanotic heart disease
- ☐ < 24 months of age who will be profoundly immunocompromised during the respiratory syncytial virus (RSV) season

A DOSE OF SYNAGIS® HAS BEEN ADMINISTERED IN AN INPATIENT SETTING ◯ Yes ◯ No	IF YES, INDICATE DATE DOSE WAS ADMINISTERED
ADDITIONAL MEDICAL JUSTIFICATION	
MEDICATIONS (include medication name, start date and end date for diagnoses that require acceptable medical therapy)	