SYNAGIS® SERVICE PRIOR-AUTHORIZATION
Maryland Medicaid Pharmacy Program
Fax form to: 1-410-333-5398
(Incomplete forms will be returned)

Recipient and Insurance Information

Recipient Name: _____MA #: _____MCO patient? ☐ Yes ☐ No

Today's date:_____Date of Service (or date shipped):_____

Date of scheduled drug injection: _____ Location: ☐ Office ☐ Residence ☐ Hospital/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 same** data elements. Changing any of these data elements will result in claim not going through.

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
	☐ lb. ☐ kg
	☐ lb. ☐ kg.
	☐ lb. ☐ kg.
	☐ lb. ☐ kg.

_____,   Date_____

Signature of Medical Staff (CNP, or RN, or MD)   Phone:_____Fax: _____

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.

Please print Name:_____Title: ☐ NCP - ☐ MD - ☐ RN

Pharmacy where Rx will be filled:_____Phone: _____

Contact Person: _____Fax: _____email:_____

FOR INTERNAL USE

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

Bill quantity of 0.5 for each 50mg vial and quantity of 1 for each 100mg vial-

The Program will never approve quantity of 1 for the 50mg vial. No 6th dose.

Approved Time frame: Oct 23 – Mar 31 - Administration Time Frame: Nov 1–Mar 31

  100mg vials-NDC 60574-4113-01 (100mg/ml) = Quantity approved: _____Days Supply_____

  50mg vials-NDC=60574-4114-01 (50mg/0.5ml) = Quantity approved: _____Days Supply_____

Exception Code Overrides:

   ☐ 4701, 4145, 4713 = PA required

   ☐ 4176 = Cost exceeds $2,500- Override needed if >1 vial is being billed (either 50mg or 100mg)

   ☐ 4194 = Therapeutic duplication if both 50mg and 100mg vials billed concomitantly (Provider may self-override)

   ☐ 4656 = Max quantity exceeds/Average daily dose exceeds

   ☐ 4452 = Time between Date Written and Date of Service exceeds plan limits

   ☐ 4134, 4135 = Quantity/Days supply exceeds

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**WORKSHEET FOR USE
IN DETERMINING THE NUMBER OF REQUIRED SYNAGIS VIALS**

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A= Recipient's actual weight used for calculating last month's injection:
_____ lb. or _____kg.   Weight measured on: _____/_____/_____

B= Calculated average weight gain *per month:_____kg/month (Difference between the last 2
consecutive weight measurement x 28 days: days intervals between the 2 measurements)

Weight measurement # 1: _____lb. or _____kg. Date taken: _____

Weight measurement # 2: _____lb. or _____kg. Date taken: _____

 * <u>Average weight gain</u>= Weight measurement #2 minus Weight measurement #1,
assuming patient did not lose weight (some infants or children may lose weight due to illness or
hospitalizations). Ex: If the days interval between the 2 measurements is 19 days, 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.

<u>NOTE:</u>

- 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.

(October 2012 DHMH)