

SYNAGIS SERVICE PRIOR-AUTHORIZATION
 Maryland Medicaid Pharmacy Program (MMPP)
 410-767-1455 or 1-800-492-5231-Option 3
Fax to: 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
	<input type="checkbox"/> lb. <input type="checkbox"/> kg
	<input type="checkbox"/> lb. <input type="checkbox"/> kg.
	<input type="checkbox"/> lb. <input type="checkbox"/> kg.
	<input type="checkbox"/> lb. <input type="checkbox"/> 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
This Service Prior-Auth Request will not be processed if not signed by a medical staff.
 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.	
Billing Time frame: Oct 23 – Mar 31 - Administration Time Frame: Nov 1–Mar 31	
(with possible extension to Apr 15 depending on reported culture data at the end of Mar)	
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 _____	
EC: <input type="checkbox"/> 4701, 4145, 4713 = PA required	
EC: <input type="checkbox"/> 4176 = Cost exceeds \$2,500- Override needed if >1 vial is being billed (either 50mg or 100mg)	
<input type="checkbox"/> 4194 = Therapeutic duplication if both 50mg and 100mg vials billed concomitantly	
<input type="checkbox"/> 4656 = Max quantity exceeds if > 1 vial of the 100mg vials is billed	
<input type="checkbox"/> 4452 = Time between Date Written and Date of Service exceeds plan limits	
<input type="checkbox"/> 4134 and 4135- Issued for long-term PA (>30 days) if no change in body weight.	

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WORKSHEET FOR USE
IN DETERMINING THE NUMBER OF VIALS TO BILL

A= Recipient's actual weight used for calculating last month's injection:
_____ lbs or _____ kgs- 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: _____ lbs or _____ kgs taken on _____

Weight measurement # 2: _____ lbs or _____ kgs taken on _____

* Average weight gain= 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 between the 2 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.