Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Synagis (Medicaid)

This fax machine is located in a secure location as required by HIPAA Regulations. Complete / Review information, sign, and date. Fax signed forms to Molina Pharmacy Prior Authorization Department at **1-888-487-9251**. Please contact Molina Pharmacy Prior Authorization Department at **1-855-322-4080** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Synagis (Medicaid).

Drug Name (select from list of drugs shown)
Synagis

Patient Information	
Patient Name:	
Patient ID:	
Patient Group No.:	
Patient DOB:	

Prescribing Physician	
Physician Name:	
Physician Phone:	
Physician Fax:	
Physician Address:	
City, State, Zip:	

Diagnosis:	ICD Code:

*****Please include all relevant clinical notes, lab work, medication history and any other applicable documentation.**

Please circle the appropriate answer for each question.

1. Is this request for continuation of therapy? ○ Y ○ N
   If the answer to this question is yes, go to question 22.
   If the answer to this question is no, go to question 2.

2. Is the patient's chronological age less than (<) 12 months at the beginning of the RSV season for the patient's county of residence? ○ Y ○ N
   If the answer to this question is yes, go to question 3.
   If the answer to this question is no, go to question 14.

3. Is the patient's gestational age less than or equal to (≤) 28 6/7 weeks? ○ Y ○ N
   If the answer to this question is yes, go to question 25.
   If the answer to this question is no, go to question 4.

4. Does the patient have a diagnosis of chronic lung disease (CLD) of prematurity? ○ Y ○ N
   If the answer to this question is yes, go to question 5.
   If the answer to this question is no, go to question 7.

5. Is the patient's gestational age less than or equal to (≤) 31 6/7 weeks? ○ Y ○ N
If the answer to this question is yes, go to question 25.
If the answer to this question is no, go to question 6.

6. Does the patient have a severe congenital abnormality of the airway? ○ Y ○ N
If the answer to this question is yes, go to question 25.
If the answer to this question is no, go to question 7.

7. Does the patient have a diagnosis of severe neuromuscular disease that compromises the handling of respiratory tract secretions? ○ Y ○ N
If the answer to this question is yes, go to question 9.
If the answer to this question is no, go to question 8.

8. Does the patient have a diagnosis of acyanotic heart disease? ○ Y ○ N
If the answer to this question is yes, go to question 9.
If the answer to this question is no, go to question 10.

9. Does the patient have 1 claim for a medication for heart disease in the last 60 days? ○ Y ○ N
If the answer to this question is yes, go to question 25.
If the answer to this question is no, go to question 10.

10. Does the patient have a diagnosis of moderate to severe pulmonary hypertension? ○ Y ○ N
If the answer to this question is yes, go to question 25.
If the answer to this question is no, go to question 11.

11. Does the patient have a diagnosis of cyanotic heart disease? ○ Y ○ N
If the answer to this question is yes, go to question 12.
If the answer to this question is no, go to question 13.

12. Is prescribing provider a pediatric cardiologist or has the prescribing provider indicated that a pediatric cardiologist has been consulted? ○ Y ○ N
If the answer to this question is yes, go to question 25.
If the answer to this question is no, go to question 13.

13. Does the patient have a diagnosis of cystic fibrosis (CF) with clinical evidence of CLD and/or nutritional compromise? ○ Y ○ N
If the answer to this question is yes, go to question 25.
If the answer to this question is no, go to question 14.

14. Is the patient less than (<) 24 months of age at the beginning of the RSV season for the patient's county of residence? ○ Y ○ N
If the answer to this question is yes, go to question 15.
If the answer to this question is no, denied.

15. Does the patient have a diagnosis of an identified disease state that will leave them profoundly immunocompromised during the RSV season? ○ Y ○ N
If the answer to this question is yes, go to question 25.
If the answer to this question is no, go to question 16.

16. Has the patient had a solid organ or hematopoietic stem cell transplant during the RSV season? ○ Y ○ N
If the answer to this question is yes, go to question 25.
If the answer to this question is no, go to question 17.

17. Is the patient less than (<) 24 months chronological age and greater than or equal to (≥) 12 months chronological age at the beginning of the RSV season for the patient's county of residence? ○ Y ○ N
If the answer to this question is yes, go to question 18.

If the answer to this question is no, denied.

18. Does the patient have a diagnosis of chronic lung disease (CLD) of prematurity? ○ Y ○ N
If the answer to this question is yes, go to question 19.
If the answer to this question is no, go to question 21.

19. Is the patient's gestational age less than or equal to (≤) 31 6/7 weeks? ○ Y ○ N
If the answer to this question is yes, go to question 20.
If the answer to this question is no, go to question 21.

20. Does the patient have a history of any of the following in the last 180 days: chronic use of corticosteroids, diuretics, long-term mechanical ventilator, bronchodilator therapy, and/or supplemental oxygen? ○ Y ○ N
If the answer to this question is yes, go to question 25.
If the answer to this question is no, go to question 21.

21. Does the patient have a diagnosis of cystic fibrosis (CF) with severe lung disease OR weight less than the 10th percentile? ○ Y ○ N
If the answer to this question is yes, go to question 25.
If the answer to this question is no, denied.

22. Has the patient been hospitalized for RSV since the last palivizumab dose? ○ Y ○ N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 23.

23. Has the pharmacy indicated the patient's weight? ○ Y ○ N
If the answer to this question is yes, go to question 24.
If the answer to this question is no, denied.

24. Did the pharmacy indicate date of last palivizumab dose? ○ Y ○ N
If the answer to this question is yes, go to question 25.
If the answer to this question is no, denied.

25. Are there greater than (>) 4 dates of service for palivizumab since the beginning of the current RSV season (determined by patient's county of residence) until today? ○ Y ○ N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 26.

26. Is the claim for 1 vial of either the 50mg or 100mg vials? ○ Y ○ N
If the answer to this question is yes, go to question 27.
If the answer to this question is no, denied.

27. Is this request for a non-preferred drug? ○ Y ○ N
The Texas Medicaid Preferred Drug List can be found at txvendordrug.com
If the answer to this question is yes, go to question 28.
If the answer to this question is no, approved for 10 days.

Comments:

I affirm that the information given on this form is true and accurate as of this date.

_____ _____

Prescriber (or Authorized) Signature Date