

**INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT  
SYNAGIS® PRIOR AUTHORIZATION REQUEST FORM**



*Pharmacy Benefit Management (PBM) Call Center*  
**4550 Victory Lane**  
**Indianapolis, IN 46203**  
**Phone: (866) 879-0106 Fax: (866) 780-2198**



Today's Date

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Will a **PHARMACY** be billing Synagis to the Indiana Medicaid program via a **PHARMACY** claim? YES  NO   
 If "No", do **NOT** submit this form to ACS. Instead, contact the managed care entity in which the patient is enrolled:

**Anthem:** 1-866-408-7187  
**MDwise:** 1-800-356-1204  
**MHS:** 1-877-647-4848

**\*\*All sections must be completed or the request will be returned\*\***

Patient's Medicaid # <input style="width: 100%;" type="text"/>	Date of Birth <input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/> / <input style="width: 60%;" type="text"/>
Patient's Name <input style="width: 100%;" type="text"/>	Prescriber's Name <input style="width: 100%;" type="text"/>
Prescriber's IN License # <input style="width: 100%;" type="text"/>	Specialty <input style="width: 100%;" type="text"/>
Prescriber's NPI # <input style="width: 100%;" type="text"/>	Prescriber's Signature <input style="width: 100%;" type="text"/>
Return Fax # <input style="width: 20%;" type="text"/> - <input style="width: 20%;" type="text"/> - <input style="width: 60%;" type="text"/>	Return Phone # <input style="width: 20%;" type="text"/> - <input style="width: 20%;" type="text"/> - <input style="width: 60%;" type="text"/>

**1. Patient Information:**  
**Actual Gestational Age:** \_\_\_\_\_ weeks \_\_\_\_\_ days      **Current Age (Must be < 24 months):** \_\_\_\_\_ months  
**Current Weight:** \_\_\_\_\_  kg  lb

**2. Prescription Information:**  Inject 15mg/kg IM once per month through March 31<sup>st</sup>  Other: \_\_\_\_\_

- 3. Palivizumab Prior Approval Criteria Guidelines for a maximum of 5 doses** (Approval will be granted under any of the following circumstances):
- Preterm infants born before 32 weeks gestation
  - Infants < 24 months of age with chronic lung disease requiring medical therapy within 6 months of the start of the RSV season
  - Infants < 24 months of age and requiring medical therapy for congenital heart disease
  - Infants < 24 months of age with neuromuscular disease or congenital abnormalities of the airways

- 4. Palivizumab Prior Approval Criteria Guidelines for a maximum of 3 doses:**
- Preterm infants with a gestational age of 32 to less than 35 weeks with at least one of the following risk factors:
    - Infant attends child care
    - Siblings living in the household are younger than 5 years of age

**Note:** Prophylaxis will be given only until the infant reaches 90 days of age or a maximum of 3 doses, which ever comes first

**The Respiratory Syncytial Virus (RSV) season is defined as November 1<sup>st</sup> through March 31<sup>st</sup>. The Office of Medicaid Policy & Planning may extend the season based on statewide virology data. Administration of additional doses will require separate prior authorization. Please note that the criterion presented on the form pertains to the IHCP pharmacy benefit only.**

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