Synagis® (palivizumab)

Medication Request Form (MRF) for Healthy Indiana Plan (HIP) and Hoosier Healthwise (HHW)

FAX TO: (858) 790-7100

c/o MedImpact Healthcare Systems, Inc.

Attn: Prior Authorization Department
10181 Scripps Gateway Court, San Diego, CA 92131 - Phone: 1-844-336-2677

Instructions:
This form is to be used by participating providers to obtain coverage for the drug listed above, which requires prior authorization. Please complete this form and fax it to Med**Impact** Healthcare Systems, Inc. at (858) 790-7100. If you have any questions regarding this process, please contact Med**Impact**'s Customer Service at 1-844-336-2677.

Member/Provider Information:

MDwise Member's Name:	**Provider's Name:**
MDwise Member's ID #:	**Provider's Specialty:**
MDwise Member's DOB (mm-dd-yy)**:**	**Provider's NPI #:**
PLEASE NOTE that ONLY the following pharmacies are contracted to provide Synagis to MDwise patients: • **Walgreens** • **Eskenazi** • **IU Health**	**Provider's (Area Code) Telephone Number/Contact Name:** **Provider's (Area Code) Fax Number:**

Clinical Information:

Requested Drug: ☐ **Synagis**	
Dose and Quantity Requested:	
Date Requested:	**Length of Treatment** (please be specific)**:**

Documentation of Medical Necessity:

1. Please list the patient's current age: _____
2. Does the patient have chronic lung disease of prematurity? ☐ Yes ☐ No
   If yes and patient is less than 12 months of age:
   Is the patient's gestational age < 32 weeks? ☐ Yes ☐ No
   AND
   Did the patient require > 21% supplemental oxygen for at least the first 28 days after birth? ☐ Yes ☐ No
   If yes and patient is 12 to 24 months of age:
   Has the patient required medical support (oxygen, bronchodilator, diuretic, or chronic steroid therapy) within 6 months of the start of the second RSV season? ☐ Yes ☐ No
3. Is the patient profoundly immunocompromised during the RSV season? ☐ Yes ☐ No
4. Did the patient undergo solid organ transplantation during the RSV season? ☐ Yes ☐ No
5. Does the patient have one of the following congenital heart conditions?
   Does the patient have acyanotic heart disease requiring medication to control chronic heart failure that will require cardiac surgical procedures? ☐ Yes ☐ No
   Does patient have moderate to severe pulmonary hypertension? ☐ Yes ☐ No
   Does the patient have cyanotic heart defect and is treatment prescribed by or in consultation with a pediatric cardiologist? ☐ Yes ☐ No
6. Was the patient born prematurely? ☐ Yes ☐ No
   If yes, at what gestational age was the patient born? _____
7. Does the patient have congenital abnormalities of the airways (anatomic pulmonary abnormalities) or neuromuscular disease that compromises the handling of respiratory secretions? ☐ Yes ☐ No

8. Is the patient an American Navajo infant?	☐ Yes	☐ No
9. Is the patient an American White Mount Apache infant?	☐ Yes	☐ No
10. Is the patient an Alaska native infant?	☐ Yes	☐ No

Please attach medical records and/or office visit notes to support the need for Synagis therapy in this patient.

Please refer to the CDC website to verify the RSV season for the patient's geographical region of residence.

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