Magellan COMPLETE CARE.

MAGELLAN COMPLETE CARE OF VIRGINIA – CCC PLUS

Service Authorization (SA) Form

Synagis®

If the following information is not complete, correct, or legible, the SA process can be delayed.

Synagis® approvals may begin therapy **November 1st**, with last date of therapy not to exceed **April 30th** (end of RSV season).

MEMBER INFORMATION

Member's Last Name:

Member's First Name:

MCC VA ID Number:

Date of Birth: – –

PRESCRIBER INFORMATION

Last Name:

First Name:

NPI Number:

DEA Number: –

Phone Number: – –

Fax Number: – –

DISPENSING INFORMATION

Name of Dispensing Pharmacy:

NPI Number:

Strength:

☐ 50 mg ☐ 100 mg

Directions: ____

Patient Weight: ____

(Form continued on next page.)

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Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

CLINICAL CRITERIA DOCUMENTATION

Do **NOT include documentation that is not requested on this form.**

1. What is the patient's gestational age? ________ weeks ________ days
2. Does the patient have Chronic Lung Disease of Prematurity (formerly called bronchopulmonary dysplasia)? If **YES**, go to 2a. If **NO**, go to 3.

☐ Yes ☐ No

2a. Did the patient receive oxygen immediately following birth? If **YES**, go to 2b. If **NO**, go to 3.

☐ Yes ☐ No

2b. Please indicate the % oxygen received: ________________ and duration of treatment: ________________

2c. Please indicate if the patient is receiving any of the following respiratory support therapies on a daily basis:

☐ Oxygen Most recent date administered: ___________________

☐ Systemic corticosteroids Most recent date administered: ___________________

☐ Diuretics Most recent date administered: ___________________

3. Does the patient have a diagnosis of Cystic Fibrosis? If **YES**, go to question 3a. If **NO**, go to 4.

☐ Yes ☐ No

3a. Has the patient been hospitalized for a pulmonary exacerbation?

☐ Yes ☐ No If **YES**, provide date: ___________________

3b. Does the patient have clinical evidence of chronic lung disease?

☐ Yes ☐ No

3c. Does the patient have clinical evidence of failure to thrive?

☐ Yes ☐ No

3d. Does the patient have pulmonary abnormalities on chest x-ray or CT that persist when the patient is stable?

☐ Yes ☐ No

3e. What is the patient's weight for length percentile? ___________________

4. Please indicate if the patient has any of the following:

☐ Anatomic Pulmonary Abnormality, specify: _________________________

☐ Neuromuscular Disorder, specify: _________________________

☐ Congenital anomaly that impairs the ability to clear secretions, specify: _________________________

(Form continued on next page.)

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Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

CLINICAL CRITERIA DOCUMENTATION (CONTINUED)

5. Please indicate if patient has any of the following:
   - ☐ HIV
   - ☐ Cancer, receiving chemotherapy
   - ☐ Organ transplant receiving immunosuppressant therapy
   - ☐ Other medical condition severely immunocompromising patient, specify: ________________________
6. Has this patient received a heart transplant?
   ☐ Yes ☐ No If **YES**, provide date of transplant: ____________________
7. Does patient have hemodynamically significant congenital heart disease? If **YES**, please indicate which type of disease:
   - ☐ Acyanotic heart disease, specify: ____
   - ☐ Cyanotic heart disease, specify: ____
     Name of Pediatric Cardiologist: ____
   - ☐ Pulmonary Hypertension
   - ☐ Other: ____
8. Will this patient's congenital heart disease require cardiac surgery?
   ☐ Yes ☐ No
9. Please list any medications that may be used:
   - ☐ Ace-inhibitor/ARB Most recent date administered: ____________________
   - ☐ Diuretic Most recent date administered: ____________________
   - ☐ Beta-blocker Most recent date administered: ____________________
   - ☐ Digoxin Most recent date administered: ____________________
   - ☐ Other cardiovascular medications Most recent date administered: ____________________
10. If this is a request for a sixth dose of Synagis during the RSV season, has the patient had an ECMO or cardiac bypass during the RSV season?
    ☐ Yes ☐ No If YES, provide date: ____________________

(Form continued on next page.)

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Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

CLINICAL CRITERIA DOCUMENTATION (CONTINUED)

11. Please note any other information pertinent to this SA request:

____

____

____

____ ______________________

Prescriber Signature (Required) **Date**

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; incomplete forms will delay the SA process. Submission of documentation does NOT guarantee coverage by Magellan Complete Care of Virginia.

The completed form may be **FAXED TO 1-800-922-3986** or mailed to:

Magellan Rx Management Prior Authorization Program
c/o Magellan Health, Inc.
11013 West Broad Street
Glen Allen, VA 23060

Phone: 1-800-424-4524 (TTY 711)

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