



# New Hampshire Medicaid Fee-for-Service Program Prior Authorization Drug Approval Form

Synagis®

DATE OF MEDICATION REQUEST:      /      /

## SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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FIRST NAME:

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MEDICAID ID NUMBER:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

DATE OF BIRTH:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

GENDER:  Male  Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

## SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

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FAX NUMBER:

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## SECTION III: CLINICAL HISTORY

- What is the patient's age? (provide patient's current age AND gestational age) \_\_\_\_\_
- Does the patient have a diagnosis of chronic lung disease and has required medical therapy (i.e., supplemental oxygen, bronchodilator, diuretic, or corticosteroid therapy) within the six months before the start of RSV season?  Yes  No  
Please list specific treatment and provide the date administered: \_\_\_\_\_
- Does the patient have any of the following risk factors? (please check all that apply)  Yes  No
 

<input type="checkbox"/> Child care attendance	<input type="checkbox"/> School aged siblings
<input type="checkbox"/> Exposure to environmental pollutants	<input type="checkbox"/> Congenital abnormalities of the airways
<input type="checkbox"/> Severe neuromuscular disease	<input type="checkbox"/> Low birth weight
<input type="checkbox"/> Long distance from hospital care	
- Does the patient have a diagnosis of hemodynamically significant cyanotic or acyanotic congenital heart disease?  Yes  No
- Does the patient have congenital heart disease AND one of the following? (please check all that apply)  Yes  No
 

<input type="checkbox"/> Moderate to severe pulmonary hypertension	<input type="checkbox"/> Receiving medications for CHF
<input type="checkbox"/> Cyanotic heart disease	
- Does the patient have any of the following conditions? (please check all that apply)  Yes  No
 

<input type="checkbox"/> Secundum atrial septal defect	<input type="checkbox"/> Small ventricular septal defect
<input type="checkbox"/> Pulmonic stenosis	<input type="checkbox"/> Uncomplicated aortic stenosis
<input type="checkbox"/> Mild coarctation of the aorta	<input type="checkbox"/> Patent ductus arteriosus
<input type="checkbox"/> Mild cardiomyopathy not receiving therapy	<input type="checkbox"/> Lesions corrected by surgery (unless w/CHF)

Please provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet:

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_