TO: Physicians, Advanced Practice Registered Nurses, Physician Assistants, and Hospitals

RE: Authorization for Palivizumab (Synagis)

This bulletin provides important information to providers regarding clinical and prior authorization (PA) requirements for Palivizumab (Synagis). This bulletin supersedes PB 2009-41 "New Prior Authorization Requirements for Synagis" and PB 2011-85 "Authorization for Palivizumab (Synagis)". This policy is effective for all treatments that have not yet been authorized for the 2016-2017 Respiratory Syncytial Virus (RSV) season and subsequent seasons.

The Department of Social Services (DSS) requires PA when prescribing Synagis to members enrolled in the Connecticut Medical Assistance Program (CMAP). Synagis is used as a prophylaxis against Respiratory syncytial virus (RSV). RSV is the most common cause of bronchiolitis and pneumonia in young infants.

PRIOR AUTHORIZATION

PA is required for Synagis in all settings except the inpatient hospital setting.

Outpatient Hospitals

For hospitals that purchase and bill for Synagis in the outpatient hospital setting, it is the hospital's responsibility to obtain prior authorization for clients enrolled in CMAP. Prior authorization for Synagis is not required during an inpatient stay. Please see CMAP's Addendum B for the reimbursement of Synagis (procedure code 90378).

Fee schedules can be accessed and downloaded from the Connecticut Medical Assistance Web site: www.ctdssmap.com.

From this Web page, go to "Provider", then to "Provider Fee Schedule Download". Click the "I accept" button and proceed to click on the CSV for the applicable fee schedule and press the control key while clicking the CSV link, then select "Open".

Physicians, Advanced Practice Registered Nurses (APRN) and Physician Assistants (PA)

The Department of Social Services requires physicians, APRNs and PAs that obtain Synagis from one of the preferred CMAP enrolled retail pharmacies to obtain prior authorization for clients enrolled in CMAP.

Prescribing providers must fax a completed PA Request Form along with any supporting clinical information to one of our preferred CMAP enrolled pharmacies. The preferred pharmacies are listed on the PA Request Form. It is the pharmacy's responsibility to submit the PA request to HUSKY Health.

Attached to this bulletin is a copy of the PA form prescribers need to complete in order for Synagis to be reviewed for prior authorization. The attached PA form must be used for all PA requests for infants/children in HUSKY A, HUSKY B and HUSKY C. Please note 1) the Synagis Outpatient Hospital Form is designed for hospitals purchasing and billing for Synagis in the outpatient hospital setting; 2) the Palivizumab (Synagis®) Prior Authorization Request Form is for Synagis that will be dispensed to providers from one of the preferred CMAP enrolled pharmacies. The PA form is also available on the HUSKY Health Web site at: www.ct.gov/husky. From

the Home page select "For Providers", and then select "Provider Bulletins & Forms", and then go to "Synagis Request Form". Physicians may call 1-800-440-5071 for more information regarding PA requirements.

Please note: PA should be obtained prior to the scheduled date of the injection to avoid delays with the pharmacy's delivery or at the outpatient setting.

CLINICAL REQUIREMENTS

There is no change to the clinical requirements. Coverage guidelines for the use of Synagis will be made in accordance with CMAP's definition of medical necessity and in line with published recommendations of the American Academy of Pediatrics. Clinical requirements can be located on www.ct.gov/husky Web page by selecting "For Providers", and then "Policies, Procedures, Guidelines", and then select "Clinical Policies", and then "Palivizumab" (Synagis)".

2016-2017
RSV Season

HUSKY Health Program
Palivizumab (Synagis®) Prior Authorization Request Form
Phone: 1.800.440.5071

THIS FORM IS TO BE COMPLETED BY THE ORDERING PROVIDER AND FAXED TO ONE OF THE PHARMACIES LISTED BELOW.

□ CVS/Caremark Phone: 1.800.237.2767 Fax: 1.800.323.2445	□ Walgreens Phone: 1.866.230.8102 Fax: 1.888.325.6544

Patient Name:	Parent/Guardian Name:
Medicaid ID#:	Address:
DOB: Birth Weight lbs oz ***OR*** kg	City/State/Zip:
Gestational Age: (weeks) / (days)	Phone:
Current Weight: lbs oz ***OR*** kg	Date Weight Recorded:
Previous Dose Given: Y / N Date:	Expected Date of First Injection:
First dose given in physician's office, subsequent doses to be administered: □ In Office/Clinic □ In Patient's Home	
Authorization expires 3/31/2017 unless otherwise indicated; HUSKY Health program to coordinate home administration.	

Criteria - Check only one category and enter the diagnosis/ICD-10CM code that is most applicable to the clinical situation.

□ **1. Infant born before 29 weeks, 0 days gestational age, and who is up to 12 months of age as of 11/01/2016 (5 Doses Max)**
- Enter one ICD-10CM code identifying patient's gestational age.
  ICD-10CM Code: _____

□ **2. Preterm infant born before 32 weeks, 0 days gestational age with chronic lung disease of prematurity defined as greater than 21% oxygen for at least 28 days after birth, and who is up to 12 months of age as of 11/01/16 (5 Doses Max)**
- Enter one ICD-10CM code identifying patient's gestational age.
  ICD-10CM Code: _____
- Enter one ICD-10CM code that best describes the patient's lung disease of prematurity.
  ICD-10CM Code: _____ (Requires documentation of oxygen needs after birth)

□ **3. Infant with hemodynamically significant heart disease and who is up to 12 months of age as of 11/01/16 (5 doses Max)**
Diagnosis _____ ICD-10CM Code _____ (Requires documentation of indicated diagnosis)

□ **4. Children between 12 and 24 months of age as of 11/01/16, born before 32 weeks, 0 days' gestation who required at least 28 days of supplemental oxygen after birth and who continues to require medical intervention (supplemental oxygen, chronic corticosteroid or diuretic therapy) (5 Doses Max)**
Diagnosis _____ ICD-10CM Code _____ (Requires documentation of oxygen needs after birth and current medical intervention(s))

□ **5. Other: Child who will be profoundly immunocompromised during the RSV season and who is up to 24 months of age as of 11/01/16 (5 Doses Max)**
Diagnosis _____ ICD-10CM Code _____ (Requires documentation of immunocompromised state)

□ **6. Other: Child with pulmonary abnormality or neuromuscular disease that impairs the ability to clear secretions from the upper airways and who is up to 12 months of age as of 11/01/16 (5 Doses Max)**
Diagnosis _____ ICD-10CM Code _____ (Requires documentation of indicated diagnosis)

Prescription

Synagis® (palivizumab) □ Syringes _____ □ Other _____

Sig □ Inject 15mg/kg one time per month Refills***** 1 2 3 4 (circle one, based on AAP recommendations)

Physician Signature: _____ Date: _____
Physician Name: _____ Office Contact: _____
Hospital/Practice: _____ Phone: _____
Address: _____ Fax: _____ NPI # _____
City/St/Zip _____ License # _____ DEA # _____

PHARMACIES SHOULD FAX COMPLETED REQUESTS TO THE HUSKY HEALTH PROGRAM AT 203.774.0549

HUSKY HEALTH PROGRAM
Palivizumab (Synagis®) Outpatient Hospital Request Form (2016-2017 RSV Season)

Date of Request: _____ **Fax to: 203.774.0549**

Hospital Name: _____
Hospital Medicaid ID: _____
Ordering Provider: _____
Address: _____
NPI#: _____
Contact: _____
Tel. #: _____
Fax #: _____

Patient Information
HUSKY Member Name: _____
HUSKY Member #: _____
Head of Household Name: _____
Telephone #: _____
Date of Birth: _____
Gestational Age (weeks/days): _____/_____
Birth Weight: _____ Present Weight: _____

Doses Ordered #: _____
Previous Dose Given: Y / N Date(s) Previous Dose(s) Administered: _____

To request authorization for a total of up to five (5) doses for administration during the expected 2016-2017 season (November 1, 2016 through March 31, 2017), please complete below:

Criteria – Check only one category and enter the diagnosis / ICD-10CM code that is most applicable to the clinical situation.

□ **1. Infant born before 29 weeks, 0 days gestational age, and who is up to 12 months of age as of 11/01/2016 (5 Doses Max)**
- Enter one ICD-10CM code identifying patient's gestational age.
  ICD-10CM Code: _____

□ **2. Preterm infant born before 32 weeks, 0 days gestational age with chronic lung disease of prematurity defined as greater than 21% oxygen for at least 28 days after birth, and who is up to 12 months of age as of 11/01/16 (5 Doses Max)**
- Enter one ICD-10CM code identifying patient's gestational age.
  ICD-10CM Code: _____
- Enter one ICD-10CM code that best describes the patient's lung disease of prematurity.
  ICD-10CM Code: _____ (Requires documentation of oxygen needs after birth)

□ **3. Infant with hemodynamically significant heart disease and who is up to 12 months of age as of 11/01/16 (5 Doses Max)**
Diagnosis: _____ ICD-10CM Code: _____ (Requires documentation of indicated diagnosis)

□ **4. Child between 12 and 24 months of age as of 11/01/16, born before 32 weeks, 0 days' gestation who required at least 28 days of supplemental oxygen after birth and who continues to require medical intervention (supplemental oxygen, chronic corticosteroid or diuretic therapy) (5 Doses Max)**
Diagnosis: _____ ICD-10CM Code: _____ (Requires documentation of oxygen needs after birth and current medical interventions)

□ **5. Other: Child who will be profoundly immunocompromised during the RSV season and who is up to 24 months of age as of 11/01/16 (5 Doses Max)**
Diagnosis: _____ ICD-10CM Code: _____ (Requires documentation of immunocompromised state)

□ **6. Other: Child with pulmonary abnormality or neuromuscular disease that impairs the ability to clear secretions from the upper airways and who is up to 12 months of age as of 11/01/16 (5 Doses Max)**
Diagnosis: _____ ICD-10CM Code: _____ (Requires documentation of indicated diagnosis)

_____
Physician Signature