Connecticut Department of Social Services
Medical Assistance Program **Provider Bulletin 2017-56**
www.ctdssmap.com **September 2017**

TO: Physicians, Advanced Practice Registered Nurses (APRNs), Physician Assistants (PAs) and Hospitals

RE: Authorization for Palivizumab (Synagis®) - 2017-2018 Respiratory Syncytial Virus (RSV) Season

This bulletin provides important information to providers regarding the clinical and prior authorization (PA) requirements for palivizumab (Synagis®) for the 2017-2018 Respiratory Syncytial Virus (RSV) season. Synagis® is used as prophylaxis against RSV, the most common cause of bronchiolitis and pneumonia in young infants.

Medical Necessity Review Criteria
There are no changes to the medical necessity review criteria for Synagis®. Coverage guidelines for the use of Synagis® will be made in accordance with the Connecticut Medical Assistance Program's (CMAP) definition of Medical Necessity and in line with published recommendations of the American Academy of Pediatrics (AAP). The review criteria are available on the HUKY Health website at www.ct.gov/husky by selecting ***"For Provider"***, ***"Medical Management"***, ***"Policies, Procedures and Guidelines"***, ***"Palivizumab (Synagis®)"***.

Prior Authorization
Prior authorization for Synagis® is required when provided to HUSKY members on an outpatient basis.

Outpatient Hospitals
The Connecticut Department of Social Services (DSS) requires that hospitals that purchase and bill for Synagis® obtain prior authorization. Prior authorization is not required when Synagis® is given as part of an inpatient admission.

Outpatient hospitals must fax a completed PA request form along with supporting clinical information to Community Health Network of Connecticut, Inc. (CHNCT) at **203.774.0549**.

Outpatient hospitals should reference CMAP's Addendum B for reimbursement of CPT code 90378 – Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each. Addendum B is available on the CMAP web site at: www.ctdssmap.com. From the home page, go to ***"Hospital Modernization"***, ***"CMAP Addendum B (Excel)"***.

Physicians, Advanced Practice Registered Nurses (APRN) and Physician Assistants (PA)
DSS requires that physicians, APRNs and PAs that obtain Synagis® from one of the preferred CMAP enrolled retail pharmacies initiate the PA process for clients enrolled in CMAP.

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

Prior Authorization Form
Attached to this bulletin are copies of the PA request forms. A PA form must be used for all Synagis® requests for HUSKY members.

The Palivizumab (Synagis®) Outpatient Hospital Request Form is designed for hospitals purchasing and billing for Synagis® in the outpatient hospital setting.

The Palivizumab (Synagis®) Prior Authorization Request Form is for Synagis® that will be dispensed to providers or home care agencies from one of the preferred CMAP enrolled pharmacies.

The Synagis® PA forms are also available on the HUSKY Health web site at www.ct.gov/husky. To access the form, click on "***For Providers***", ***"Medical Management", "Provider Forms***".

For questions regarding the prior authorization process, please contact CHNCT at 1**.800.440. 5071**, Monday through Friday, between the hours of 8:00 a.m. and 6:00 p.m.

For questions about billing or if further assistance is needed to access the fee schedules on the CMAP web site, please contact the DXC Technology Provider Assistance Center at 1.800.842.8440, Monday through Friday between the hours of 8:00 a.m. and 5:00 p.m.

HUSKY HEALTH PROGRAM
Palivizumab (Synagis®) Outpatient Hospital Request Form (2017-2018 RSV Season)

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

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 2017-2018 season (November 1, 2017 through March 31, 2018), 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 11/01/2017 (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 11/01/17 (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 11/01/17 (5 Doses Max)**

Diagnosis: _____ ICD-10CM Code: _____ (Requires documentation of indicated diagnosis)

□ **4. Child between 12 and 24 months of age as of 11/01/17, 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 11/01/17 (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 11/01/17 (5 Doses Max)**

Diagnosis: _____ ICD-10CM Code: _____ (Requires documentation of indicated diagnosis)

_____

Physician Signature

2017-2018
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	Walgreens
Phone: 1.800.237.2767 Fax: 1.800.323.2445	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 3/31/2018 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 11/01/2017 (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 11/01/17 (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 11/01/17 (5 doses Max)**
Diagnosis_____ICD-10CM Code_____(Requires documentation of indicated diagnosis)

□ **4. Children between 12 and 24 months of age as of 11/01/17, 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 11/01/17 (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 11/01/17 (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