



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

RE: Authorization for Palivizumab (Synagis®) - 2019-2020 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 2019-2020 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 HUSKY Health Web site at www.ct.gov/husky by selecting "**For Provider**", "**Medical Management**", "**Policies, Procedures and Guidelines**", "**Palivizumab (Synagis®)**".

Prior Authorization

Prior authorization (PA) 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 PA. PA 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 Current Procedural Terminology (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 (APRNs) and Physician Assistants

DSS requires that Physicians, APRNs and Physician Assistants that obtain Synagis® from one of the preferred CMAP enrolled retail pharmacies initiate the PA process for members 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 Provider Assistance Center at 1-800-842-8440, Monday through Friday between the hours of 8:00 a.m. and 5:00 p.m.

**2019-2020
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.

<input type="checkbox"/> CVS/Caremark Phone: 1.800.237.2767 Fax: 1.800.323.2445	<input type="checkbox"/> Walgreens Phone: 1.866.230.8102 Fax: 1.888.325.6544
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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: <input type="checkbox"/> In Office/Clinic <input type="checkbox"/> In Patient's Home	
Authorization expires 3/31/2020 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 11/01/2019 (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 AND 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 11/01/19 (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 11/01/19 (5 doses Max)**
Diagnosis _____ ICD-10CM Code _____ (Requires documentation of indicated diagnosis)
- 4. Children between 12 and 24 months of age as of 11/01/19, 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 11/01/19 (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 11/01/19 (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