Nevada Medicaid

Submit fax request to: 855-455-3303

Please note: All information below is required to process this request.

Synagis® Authorization Request Form

For a prescribing physician to request Synagis® for the Nevada Respiratory Syncytial Virus (RSV) season September 1, 2021, through March 31, 2022. Synagis® authorization will not be issued for therapy dates in the 2021-2022 season after March 31, 2022.

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED.

Member Information (required)			**Provider Information (required)**		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength(s) of vial(s) to be dispensed:	Number of single dose vials (whole number) for each strength:
☐ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Demographics:

Gestational Age: _____ Weeks: _____ Days: _____ (Both weeks and days are required)

Current Weight: _____ Date on which current weight was recorded: _____

If Hospice, list Hospice Diagnosis: _____

Please check the applicable boxes to indicate each item as true for the recipient:

☐ Child is <12 months of age at the onset of RSV season on September 1 (born after 09/01/20).

☐ Child is <24 months of age at the onset of RSV season on September 1 (born after 09/01/19).

☐ Child has a diagnosis of chronic lung disease of prematurity (formerly called bronchopulmonary dysplasia).

☐ Child has required medical treatment for chronic lung disease of prematurity in the preceding six months (only required if child is ≥ 12 months of age). *Please check all that apply and document administration dates:*

- ☐ Oxygen Most recent date administered: _____
- ☐ Corticosteroids Most recent date administered: _____
- ☐ Bronchodilators Most recent date administered: _____
- ☐ Diuretics Most recent date administered: _____

☐ Child has hemodynamically significant cyanotic or acyanotic congenital heart disease (CHD)
Please check all that apply, and document medications received or date of surgeries:

- ☐ Congestive heart failure/cardiomyopathy; Medications: _____
- ☐ Moderate to severe pulmonary hypertension; Medications: _____
- ☐ Cyanotic heart disease; Medications: _____
- ☐ Cardiopulmonary bypass surgery and continues to require prophylaxis after surgery or at the conclusion of extracorporeal membrane oxygenation; Date: _____
- ☐ Other diagnosis; Document: _____ Medications: _____

☐ The child has congenital abnormalities of the airways or neuromuscular disease. Document: _____

☐ The child has a neuromuscular disease that impairs the ability to clear secretions from the upper airway.
Document diagnosis:_____

☐ Child has had a cardiac transplant; Date of transplant: _____

☐ Child is severely immunocompromised during the RSV season; Document: _____

☐ Child has cystic fibrosis: (*please check all that apply):*

- ☐ Child has clinical evidence of chronic lung disease.
- ☐ Child has clinical evidence of nutritional compromise.
- ☐ *For children with cystic fibrosis ≥ 12 months of age*:
  Weight-for-length less than 10th percentile; Length: _____
- ☐ Child has had previous hospitalization for pulmonary exacerbation in the first year of life.
- ☐ Child has abnormalities on chest radiography or chest computed tomography that persists when stable.

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.