Maryland Medicaid
Pharmacy Program
Fax: (866) 440-9345
Phone:(800) 932-3918

Synagis® Service Prior-Authorization form
Incomplete forms will be returned

Date: ____________________

Patient Information

Patient Name: ____________________________ MA#: _______________________ Date of Birth: _________________

Date of Service: ___________________ Next injection date: ________________ Location: ❑ Office ❑ Clinic

MCO patient? ❑ Yes ❑ No

Once prior authorization (PA) has been issued for the requested date of service and quantity/days of supply, providers must resubmit the claim using **exact** data elements. Changing any of the information will result in a rejection claim. Do not use different dates when referring to the same shipment (i.e., when date of service could refer to either the billing date or shipping date, such date must be consistent with provider's record keeping).

Third Party Liability: List other insurance: ____

Maryland Medicaid is always the payer of last resort. List units dispensed and payment made by other insurance for coordination of benefits:

NDC **66658-0230-01**(50mg/0.5ml vial). Quantity billed: _____________ Other insurance paid: $ ____________

NDC **66658-0231-01**(100mg/1ml vial). Quantity billed: ______________ Other insurance paid: $ ____________

Refer to the next page for instructions on determining number of Synagis vials to ship

Patient's Weight History. *A minimum of three prior weight measurements are required to process each Service PA*

Date weight measured	Weight as documented on medical record

Any breakthrough RSV and/or hospitalization during the RSV season? Specify date: _______________________

I certify the validity of the patient's weight data as submitted. Supporting medical documentation is available in the patient's medical record for the weights based on which the doses were calculated.

MDH and prescriber acknowledge and agree that this request may be executed by electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original signature.

Prescriber: _____________________________ Signature: __________________________ Date: _______________

Pharmacy name: ____

Contact person: ____

Phone: ________________________________ Fax: _______________________________

MDH - October 2023

Worksheet For Determining the Number of Required Synagis Vials

A = Weight used for calculating last month's injection: __________ kg   Date measured: ___________

B = Average monthly weight gain*: __________ kg (difference between the last 2 consecutive weight x 28 days)

Weight # 1: ________kg   Taken on: _________________

Weight # 2: ________kg.   Taken on: _________________

*Average monthly weight gain = Weight #2 minus weight #1 and then multiply the result with 28 assuming the patient did not lose weight (some patients may lose weight due to illness or hospitalizations). Example: if the interval between two measurements is 19 days, then prorate the value per 28 days.

C= Estimated weight to be used in dosing this month: Add the average monthly weight gain (B) to the previous month's weight (A):

C = A + B

Estimated dose for this month = 15mg × Estimated weight (C)

Number of vials to bill and ship: _______

NOTES

- Dose must be rounded up or down to the closest vial size. A maximum of 5% rounding down is allowed.
- Service Prior-auth will be granted within 24 hours between October 23rd through March 31st of the RSV season. The prescriber's office must complete and fax this Service PA form to the pharmacy each month to request a shipment of Synagis once the prior auth is approved for the entire RSV season.

MDH - October 2023