

EL PASO FIRST

Health Plans, inc.

Dear Providers:

The 2011-2012 Synagis season is approaching. Statistics indicate RSV appears earlier in some counties and remains active in others. Based on this, the state has determined the start date for Region 10, will be November 1, 2011 and terminate on March 31, 2012.

STAR Members:

The provider or provider's agent must send a prescription for Synagis® with supporting clinical documentation on the Texas Medicaid Prior Authorization request form to a Texas Medicaid-enrolled pharmacy that is a member of the Synagis® Distribution Network. This form may be obtained at www.TMHP.com:

[Texas Medicaid Palivizumab \(Synagis\) Prior Authorization Request Form](#)

CHIP & TPA Members:

Providers are required to send in a Prior Authorization Request form along with documentation validating that the member's needs meet the medical necessity requirements of the American Academy of Pediatrics guidelines. Pre-Authorization requests can be faxed to El Paso First, Utilization Department at 915-298-7881.

For additional information concerning Synagis administration for STAR Members, please call the TMHP Contact Center at 1-822-925-9126 or the TMHP CSHCN Services Program Contract Center at 1-822-568-2413.

For additional information concerning CHIP and Preferred Administrative Members, please call El Paso First Health Plans at 915-532-3778 regarding the El Paso First Health Plans' Synagis RSV program.

Sincerely,



Dr. David Palafix
Medical Director
El Paso First Health Plans

**TEXAS MEDICAID VENDOR DRUG PROGRAM FOR OUTPATIENT PHARMACIES
SYNAGIS® (PALIVIZUMAB) PRIOR AUTHORIZATION REQUEST & PRESCRIPTION FORM for 2011**

Prescribing practitioner should fax completed form to the dispensing pharmacy

Pharmacy Name: _____ Phone # _____ Fax # _____

Patient Name: _____		Texas Medicaid Recipient Number: _____	
Date of Birth: _____	Telephone Number: _____	Telephone Number: _____	
Address: _____		City: _____	State: _____ Zip: _____
County of residence: _____			
Parent/Legal Guardian (if applicable): _____			
Age (in months) as of October 1 st : _____ months		Estimated gestational age at birth: _____ completed weeks: _____ days	
Current weight _____			
<input type="checkbox"/> If < 24 months chronological age at the start of the RSV season, can qualify based on criteria to the right. Diagnoses and conditions must be clearly documented in the patient's medical record. Date of birth on or after 09/30/2009 (See Medicaid Bulletin NO. 199 November/December 2006 for details related to congenital heart and chronic lung disease diagnoses.)	<input type="checkbox"/> Active diagnosis of hemodynamically significant heart disease: (Specify ICD-9 Code(s)) _____ OR <input type="checkbox"/> Active diagnosis of Chronic Lung Disease of Infancy: (Specify ICD-9 Code(s)) _____ AND (applying to either/both of above) Required any of the following therapies within the past 6 months <input type="checkbox"/> Supplemental oxygen <input type="checkbox"/> Steroids (systemic or inhaled) <input type="checkbox"/> Digitalis <input type="checkbox"/> Mechanical ventilation <input type="checkbox"/> Diuretics <input type="checkbox"/> Routine/frequent use of bronchodilators *Chronic lung disease (CLDI) was formerly called bronchopulmonary dysplasia. It can develop in preterm neonates treated with oxygen and positive pressure ventilation. Many cases are seen in infants who previously had respiratory distress syndrome (RDS). CLDI is not asthma, croup, recurrent upper respiratory infections, chronic bronchitis, bronchiolitis, or a history of a previous RSV infection. OR <input type="checkbox"/> Solid organ or stem cell transplant recipient (Specify ICD-9 Code): _____		
<input type="checkbox"/> If < 12 months chronological age at the start of the RSV season, can qualify based on criteria to the right. Date of birth on or after 09/30/2010	<input type="checkbox"/> ≤ 28 6/7 weeks gestational age at birth (Specify ICD-9 Code): _____ OR <input type="checkbox"/> <35 weeks gestational age and severe neuromuscular disease (including chronic respiratory failure) (Specify ICD-9 Code): _____ OR <input type="checkbox"/> <35 weeks gestational age and significant congenital anomalies of the airway, expected to compromise ventilation (Specify ICD-9 Code): _____		
<input type="checkbox"/> If < 6 months chronological age at the start of the RSV season, can qualify based on criteria to the right. Diagnoses, conditions and risk factors must be clearly documented in the patient's medical record. Date of birth on or after 03/31/2011	<input type="checkbox"/> 29 through 31 6/7 weeks gestational age: (Specify ICD-9 code) _____ OR <input type="checkbox"/> 32 through 34 6/7 weeks gestational age: (Specify ICD-9 code): _____ AND two of the following: <input type="checkbox"/> Direct exposure to tobacco smoke or other documented environmental air pollutants. <input type="checkbox"/> Attends child care. <input type="checkbox"/> Siblings who attend school or child care. OR <input type="checkbox"/> Cystic Fibrosis (Specify ICD-9 Code): _____		
Current clinical information and diagnoses pertaining to medical necessity: (add additional page if necessary)			
Rx: <input type="checkbox"/> Synagis® (palivizumab) Liquid Solution 50mg and/or 100mg vials Sig: Inject 15mg/kg one time per month. Quantity: QS for weight based dosing Refills: _____ <input type="checkbox"/> Syringes 1ml 25G 5/8" <input type="checkbox"/> Syringes 3ml 20G 1" <input type="checkbox"/> Epinephrine 1:1000 amp. Sig: Inject 0.01mg/kg as directed <input type="checkbox"/> Known Allergies: _____ <input type="checkbox"/> Other: _____			
Physician Name (printed) _____		Date _____	
Address _____			
City _____	State _____	ZIP _____	Phone _____ Fax _____
Physician Signature _____		Texas License No. _____	

Dispensing Pharmacy should fax completed form to Texas Prior Authorization Center for approval: 1-866-617-8864

PLEASE NOTE: All services requiring pre-certification (other than on an emergency basis) must be approved in advance by a HMO Medical Director/designee. Pre-certification is subject to all terms and conditions of the Health Service Contract and is only valid for eligible health plan member at time of service.

FACILITY NAME: _____
FACILITY ADDRESS: _____

City State Zip Code
TPI #: _____ **NPI #:** _____
CONTACT PERSON: _____
PHONE: _____ **FAX:** _____
PROCEDURE CODES (CPT CODE): _____
IF PATIENT IS TRANSFER, FROM WHAT FACILITY: _____
PATIENT ARRIVED BY: AIR AMBULANCE LAND AMBULANCE PRIVATE TRANSPORT OTHER
OTHER INSURANCE: _____ SSI

NOTE: PLEASE FAX INITIAL CLINICAL INFORMATION WITHIN 24 HOURS OF ADMISSION TO THE UM UNIT AT 915-298-5278, FAILURE TO DO SO MAY RESULT IN DELAY OR DENIAL OF AUTHORIZATION. EL PASO FIRST REQUESTS SUBSEQUENT CLINICAL INFORMATION EVERY OTHER DAY.

MEMBER NAME: _____ **MEMBER I.D.:** _____
DOB: _____ **MR #:** _____ **ACCT #:** _____
ADMIT DATE: _____ **RM #:** _____ **DISCHARGE DATE (if applicable):** _____
ADMITTING PHYSICIAN: _____ **ADMITTING DIAGNOSIS (ICD-9):** _____
OTHER DIAGNOSIS (ICD-9): _____

ADMITTING Physician's Name: _____
TPI #: _____ **NPI #:** _____
CONTACT PERSON: _____
PHONE: _____ **FAX:** _____
PROCEDURE CODES (CPT CODE): _____ **TYPE OF SERVICE:** _____

SURGEON'S Name: _____
TPI #: _____ **NPI #:** _____
CONTACT PERSON: _____
PHONE: _____ **FAX:** _____
PROCEDURE CODES (CPT CODE): _____ **TYPE OF SERVICE:** _____

OTHER Physician's Name: _____
TPI #: _____ **NPI #:** _____
CONTACT PERSON: _____
PHONE: _____ **FAX:** _____
PROCEDURE CODES (CPT CODE): _____ **TYPE OF SERVICE:** _____