FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR SYNAGIS INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

ForwardHealth members are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member ID number per Wis. Admin. Code § DHS 104.02(4).

Under Wis. Stat. § 49.45(4), personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

PA requests for Synagis submitted on paper require the use of this form. Attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request.

INSTRUCTIONS

Prescribers are required to complete, sign, and date the Prior Authorization Drug Attachment for Synagis form, F-00142, to request PA for Synagis. Prescribers are required to retain a completed copy of the form.

Prescribers may submit PA requests in one of the following ways:

- For PA requests submitted through the Drug Authorization and Policy Override (DAPO) Center, prescribers may call 800-947-9627. A prescriber, or their designees, should have all PA information completed before calling the DAPO Center to obtain PA.
- For PA requests submitted on the ForwardHealth Portal, prescribers can access www.forwardhealth.wi.gov/.
- For PA requests submitted by fax, prescribers should submit a Prior Authorization Request Form (PA/RF), F-11018, and the appropriate PA drug attachment form to ForwardHealth at 608-221-8616.
- For PA requests submitted by mail, prescribers should submit a PA/RF and the appropriate PA drug attachment form to the following address:

  ForwardHealth
  Prior Authorization
  Ste 88
  313 Blettner Blvd
  Madison WI 53784

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I – MEMBER AND PROVIDER INFORMATION

Element 1: Name – Member

Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth ID card and the Enrollment Verification System do not match, use the spelling from the Enrollment Verification System.

Element 2: Member ID Number

Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the Enrollment Verification System to obtain the correct member ID.

Element 3: Date of Birth – Member

Enter the member's date of birth in mm/dd/ccyy format.

Element 4: Name – Prescriber
Enter the name of the medical practitioner prescribing the medication for PA.

Element 5: National Provider Identifier – Prescriber
Enter the prescribing provider's 10-digit National Provider Identifier.

Element 6: Phone Number – Prescriber
Enter the phone number, including area code, of the prescriber.

Element 7: Address – Prescriber
Enter the address (street, city, state, and zip+4 code) of the prescriber.

Element 8: Name – Billing Provider
Enter the name of the billing provider. If a prescriber or a prescriber's clinic or group intends to submit the claim, enter the prescriber or prescriber's clinic or group name. If a pharmacy intends to submit the claim, enter the pharmacy's name.

Element 9: National Provider Identifier – Billing Provider
Enter the National Provider Identifier of the billing provider. If a prescriber or a prescriber's clinic or group intends to submit the claim, enter the prescriber or prescriber's clinic or group National Provider Identifier. If a pharmacy intends to submit the claim, enter the pharmacy's National Provider Identifier.

SECTION II – MEDICAL INFORMATION FOR ALL PRIOR AUTHORIZATION (PA) REQUESTS

Element 10
Indicate whether or not the child has received Synagis during the current respiratory syncytial virus (RSV) season (November 1 through April 30). If yes, indicate the number of Synagis doses the child received and the dates of the administration in the spaces provided.

Element 11
Enter the current weight of the child in kilograms. Weights should be given to one decimal place.

Element 12
Enter the date the child was weighed for the amount listed in Element 11.

Element 13
Enter the calculated dosage of Synagis (15 milligrams per kilogram of body weight) for the child to receive. The dosage should be given as a whole number (no decimals). The following table includes the weight range, the rounded calculated Synagis dose, and the number of 50 mg units of Synagis used for the adjudication of PA requests to determine the allowed billing units.

Weight Range (in Kilograms)	Synagis Calculated Dose	Number of Units*
Up to 3.6 kg	1–54 mg	1
3.7–6.9 kg	55 mg–104 mg	2
7.0–10.2 kg	105 mg–154 mg	3
10.3–13.6 kg	155 mg–204 mg	4
13.7–16.9 kg	205 mg–254 mg	5
17.0–20.3 kg	255 mg–304 mg	6

* Units are a 50 mg dose.

Element 14
Check the primary medical condition that should be considered for approval of the PA request. (Only one condition may be selected.)

Element 15
Enter the diagnosis code for the medical condition selected in Element 14.

SECTIONS III A, III B, III C, III D, III E, III F, or III G
Providers are required to complete **one** of either Section III A, III B, III C, III D, III E, III F, or III G (depending on the child's primary medical condition identified in Element 14).

SECTION III A – MEDICAL INFORMATION FOR PRE-TERM INFANTS

Element 16
Indicate whether or not the child is younger than 12 months of age at the start of the current RSV season (November 1) **and** was born before 29 weeks gestation (that is, zero days through 28 weeks, six days)?

Element 17
Indicate the child's gestational age at delivery (in weeks and days).

SECTION III B – MEDICAL INFORMATION FOR CHRONIC LUNG DISEASE OF PREMATURITY

Element 18
Indicate whether or not the child required oxygen at greater than 21 percent for at least the first 28 days after birth.

Element 19
Indicate the child's gestational age at delivery (in weeks and days).

Element 20
Indicate whether or not the child is younger than 12 months of age at the start of the current RSV season (November 1)?

Element 21
If the child is between 12 and 24 months of age at the start of the current RSV season (November 1), indicate all therapies that the child has continuously used over the past six months.

SECTION III C – MEDICAL INFORMATION FOR PULMONARY ABNORMALITIES AND NEUROMUSCULAR DISEASE

Element 22
Indicate whether or not the child has a neuromuscular disease or congenital abnormality that impairs the ability to clear secretions from the upper airway because of an ineffective cough **and** is younger than 12 months of age at the start of the current RSV season (November 1).

SECTION III D – MEDICAL INFORMATION FOR CONGENITAL HEART DISEASE

Element 23
Indicate whether or not the child has hemodynamically significant congenital heart disease **and** is younger than 12 months of age at the start of the current RSV season (November 1).

SECTION III E – MEDICAL INFORMATION FOR CARDIAC TRANSPLANT

Element 24
Indicate whether or not the child is scheduled to undergo a cardiac transplantation during the current RSV season **and** is younger than 24 months of age at the start of the current RSV season (November 1).

SECTION III F – MEDICAL INFORMATION FOR IMMUNOCOMPROMISED CHILDREN

Element 25
Indicate whether or not the child is profoundly immunocompromised **and** younger than 24 months of age at the start of the current RSV season (November 1). If yes, indicate which of the medical conditions the child has. If other is selected, provide detailed clinical information regarding the child's medical condition and why a Synagis PA is being requested for the child.

SECTION III G – MEDICAL INFORMATION FOR OTHER REQUESTS

Element 26
Provide detailed clinical information regarding the child's medical condition and why the prescriber is requesting a Synagis PA for the child.

SECTION IV – AUTHORIZED SIGNATURE

Element 27: Signature – Prescriber
The prescriber is required to complete and sign this form.

Element 28: Date Signed – Prescriber
Enter the month, day, and year the form was signed by the prescriber in mm/dd/ccyy format.

SECTION V – ADDITIONAL INFORMATION

Element 29
Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may be included here.