FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR SYNAGIS®
COMPLETION INSTRUCTIONS

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

Members of ForwardHealth 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 identification number (DHS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., 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.

Prior authorization requests for Synagis® submitted on paper require the use of this form. If necessary, 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 and sign 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:

1) For 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.

2) For requests submitted on the ForwardHealth Portal, prescribers can access *www.forwardhealth.wi.gov/.*

3) 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.

4) 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 (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Member Identification Number
Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS 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 (NPI) — Prescriber
Enter the prescribing provider's 10-digit National Provider Identifier (NPI).

Element 6 — Address — Prescriber
Enter the address (street, city, state, and ZIP+4 code) of the prescriber.

Element 7 — Telephone Number — Prescriber
Enter the telephone number, including area 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 — NPI — Billing Provider
Enter the NPI 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 NPI. If a pharmacy intends to submit the claim, enter the pharmacy's NPI.

SECTION II — CLINICAL INFORMATION FOR ALL PA REQUESTS

Element 10
Indicate whether or not Synagis® was administered when the child was hospitalized. If yes, indicate the date(s) of administration in the space(s) provided. (No more than five doses will be authorized, inclusive of any hospital-administered doses.)

Element 11 — Current Weight — Child
Enter the child's current weight in kilograms.

Element 12 — Date Child Weighed
Enter the date the child was weighed for the amount listed in Element 11.

Element 13 — Calculated Dosage of Synagis®
Enter the calculated dosage of Synagis® (15 milligrams per kilogram of body weight). 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 kg)	Synagis® Calculated Dose	Number of Units*
Up to 3.6 kg	0 – 54 mg	1
3.7 to 6.9 kg	55 mg – 104 mg	2
7.0 to 10.2 kg	105 mg – 154 mg	3
10.3 to 13.6 kg	155 mg – 204 mg	4
13.7 to 16.9 kg	205 mg – 254 mg	5
17.0 to 20.3 kg	255 mg – 304 mg	6

* Units are a 50 mg dose.

SECTIONS III A, III B, III C, III D, III E, or III F
Providers are required to complete *one* of either Section III A, III B, III C, III D, III E, or III F (depending on the child's medical condition) for a PA request to be considered for approval. Providers should indicate the reason for administration of Synagis®. Under the appropriate condition, check the boxes and/or indicate the information that apply to the member's medical condition.

SECTION III A — CLINICAL INFORMATION FOR CHRONIC LUNG DISEASE

Element 14
Indicate whether or not the child has chronic lung disease of prematurity.

Element 15
Indicate whether or not the child required oxygen at greater than 21 percent for at least the first 28 days after birth.

Element 16
Indicate the child's gestational age at delivery (in weeks and days).

Element 17
Check the boxes to indicate the therapies that the child has continuously used over the past six months.

SECTION III B — CLINICAL INFORMATION FOR CONGENITAL HEART DISEASE

Element 18
Indicate whether or not the child is younger than 12 months of age at the start of the respiratory syncytial virus (RSV) season and has hemodynamically significant congenital heart disease.

SECTION III C — CLINICAL INFORMATION FOR CARDIAC TRANSPLANT

Element 19
Indicate whether or not the child is younger than 24 months of age at the start of the RSV season and is scheduled to undergo a cardiac transplantation during the RSV season.

SECTION III D — CLINICAL INFORMATION FOR PRE-TERM INFANTS

Element 20
Indicate whether or not the child is younger than 12 months of age at the start of the RSV season and was born before 29 weeks gestation (i.e., zero days through 28 weeks, six days). In the space provided, indicate the child's gestational age at delivery (in weeks and days).

SECTION III E — CLINICAL INFORMATION FOR PULMONARY ABNORMALITIES AND NEUROMUSCULAR DISEASE

Element 21
Indicate whether or not the child is younger than 12 months of age at the start of the RSV season and has a neuromuscular disease or congenital abnormality that impairs the ability to clear secretions from the upper airway because of an ineffective cough. If yes, indicate the disease or anomaly in the space provided.

SECTION III F — CLINICAL INFORMATION FOR IMMUNOCOMPROMISED CHILDREN

Element 22
Indicate whether or not the child, who is younger than 24 months of age at the start of the RSV season, is profoundly immunocompromised due to a solid organ transplant, stem cell transplant, receiving chemotherapy, Acquired Immune Deficiency Syndrome (AIDS), or another cause. If Other, enter the cause of the child's immunodeficiency in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

Element 23 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 24 — 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 25
Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may be included here.