Wyoming
Department
of Health

Division of Healthcare Financing

Medicaid Pharmacy News

Dear Providers: October 29, 2013

SYNAGIS® PRIOR AUTHORIZATION PROCEDURE

Prior authorization is required for ALL Synagis® claims. There is a separate authorization request form that is required and it is available in this newsletter, as well as at http://wymedicaid.org/pa. The ***prescriber must sign*** the prior authorization request form and the client's gestational age must be provided for the first dose. For ***EACH*** dose, the client's weight, the anticipated administration date, the previous dose administration date, and the date of submission of the prior authorization must be included. The prescriber (or prescriber's agent) must also initial the form for each dose. Authorizations for subsequent doses will not be approved without the previously mentioned information being updated for each dose. Additionally, requests will only be allowed at a dosing interval of not less than 28 days between injections. Claims submitted for a day supply less than 28 days may be subject to recovery.

The Wyoming Department of Health will **only approve five (5) doses** of therapy with Synagis per client per season. Therefore, if the RSV season has not begun in the client's area of the state, consideration should be given to delaying the start of administration of Synagis to avoid exceeding the Wyoming Medicaid dosing limits. If the medication is needed later in the season and the patient has already received their five doses (5) of Synagis, there is **no guarantee that an additional dose will be approved**. Keep in mind that last year RSV was not detected in CO, WY, MT, SD and ND until December and cleared in April. Please be cognizant of what is occurring in your area.

Wyoming Medicaid will approve Synagis® prior authorization requests that meet the criteria below. If a client does not meet the criteria, please provide as much information as possible, and those requests will be reviewed by the state on a case by case basis:

- **CHRONIC LUNG DISEASE:** Client is ≤24 months of age at start of therapy and has chronic lung disease of prematurity (i.e. bronchopulmonary dysplasia) requiring medication (bronchodilator, diuretic, or chronic corticosteroid therapy) or oxygen within 6 months of the start of RSV season.
- **CONGENITAL HEART DISEASE:** Client is ≤24 months of age at start of therapy and has hemodynamically significant congenital heart disease and one or more of the following:
  - Is receiving medication to control congestive heart failure
  - Has a diagnosis of moderate to severe pulmonary hypertension
  - Has a diagnosis of cyanotic heart disease
- **PREMATURITY:**
  - Client is ≤12 months of age at the start of RSV season and born at ≤28 weeks, 6 days gestational age.
  - Client is ≤12 months of age at the start of RSV season and born at 34 weeks, 6 days or less gestational age and has either severe neuromuscular disease or congenital abnormalities, either of which compromise handling of respiratory secretions.
  - Client is ≤6 months of age at the start of RSV season and born between 29 weeks, 0 days and 35 weeks, 6 days gestational age.

FAX completed form to
Goold Health Systems, an Emdeon company
1-866-964-3472

Wyoming Medicaid – Pharmacy Services Program
MULTIPLE USE**
PRIOR AUTHORIZATION REQUEST FORM

PHONE:
(For questions or inquiries ONLY)
1-877-207-1126

SYNAGIS®

Provider must fill in all information below. It must be legible, correct and complete or the form will be returned.

Client ID #: |_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Client's Full Name: _____ DOB: _____

Prescriber NPI: |_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Prescriber's Full Name: _____ Phone: _____

Prescriber Address: _____ Fax: _____

Pharmacy NPI: |_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Pharmacy Name: _____ Phone: _____

Wyoming Medicaid will approve Synagis® PA requests for clients that meet the guidelines below. Requests will only be approved for a maximum of 5 doses at a dosing interval of not less than 28 days between injections. Claims submitted for a day supply less than 28 days may be subject to recovery.

CLIENT'S GESTATIONAL AGE: _____

MEDICAL NECESSITY DOCUMENTATION *(Please check all that apply):*

- ☐ **CHRONIC LUNG DISEASE:** Client is ≤ 24 months of age at start of therapy and has chronic lung disease of prematurity (i.e. bronchopulmonary dysplasia) requiring medication (bronchodilator, diuretic, or chronic corticosteroid therapy) or oxygen within 6 months of the start of RSV season.
- ☐ **CONGENITAL HEART DISEASE:** Client is ≤24 months of age at start of therapy and has hemodynamically significant congenital heart disease and one or more of the following: (Please check all that apply)
  - ☐ Is receiving medication to control congestive heart failure
  - ☐ Has a diagnosis of moderate to severe pulmonary hypertension
  - ☐ Has a diagnosis of cyanotic heart disease.
- ☐ **PREMATURITY:**
  - ☐ Client is ≤12 months of age at start of RSV season and born at **≤28 weeks, 6 days** gestational age.
  - ☐ Client is ≤12 months of age at start of RSV season and born at **34 weeks, 6 days or less** gestational age and has either severe neuromuscular disease or congenital abnormalities, either of which compromise handling of respiratory secretions.
  - ☐ Client is ≤ 6 months of age at start of RSV season and born between **29 weeks, 0 days** and **35 weeks, 6 days** gestational age.
- ☐ **OTHER (Please include any applicable information including gestational age if client was born premature and does not meet the above criteria):**
  _____

Please indicate if the client has received Synagis® in an inpatient setting. If yes, provide the date(s) of administration and dose:
☐ *No* ☐ *Yes* ***Administration Date(s):*** _____ ***Dose:*** _____

****Please submit (by fax) the same PA form per client per season****

SYNAGIS®	STRENGTH	ANTICIPATED ADMINISTRATION DATE	PREVIOUS DOSE ADMINISTRATION DATE	CLIENT'S WEIGHT	PRESCRIBER'S INITIALS
1st Dose				Lbs oz.	
2nd Dose				Lbs oz.	
3rd Dose				Lbs oz.	
4th Dose				Lbs oz.	
5th Dose				Lbs oz.	

Prescriber Signature: _____ **Date(s) of Submission:** _____ _____ _____ _____ _____
**MUST MATCH PRESCRIBER LISTED ABOVE* *1ST DOSE* *2ND* *3RD* *4TH* *5TH*

American Academy of Pediatrics-Website: *http://aapredbook.aappublications.org/cgi/content/full/2009/1/3.110*

STATE MAXIMUM ALLOWABLE COSTS

In November, Wyoming Medicaid will be implementing a State Maximum Allowable Cost (SMAC) of $0.00381 on all oral vehicles (i.e., Ora-Sweet, Ora-Plus, Flavor Sweet, Flavor Plus, etc.). The SMAC is the maximum allowable cost the State of Wyoming will pay for these ingredients. For more information regarding these ingredients and the implemented SMAC pricing, please refer to www.wymedicaid.org.