

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 on a PA drug attachment form in one of the following ways:

- 1) For requests submitted through the Drug Authorization and Policy Override Center, prescribers may call (800) 947-9627.
- 2) For requests submitted on the ForwardHealth Portal, prescribers can access www.forwardhealth.wi.gov/.
- 3) For paper PA requests 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 paper PA requests by mail, prescribers should submit a PA/RF and the appropriate PA drug attachment form to the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

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).

The following table includes the weight range, the rounded calculated Synagis® dose, and the number of 50 mg units of Synagis® and is 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.

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 medical practitioner'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. Prescribers who are certified by Wisconsin Medicaid should indicate their name and NPI as the billing provider on the PA request. Prescribers who are not certified by Wisconsin Medicaid should indicate on the PA request the name and NPI of the Wisconsin Medicaid-certified billing provider (e.g., clinic) with which they are affiliated.

Element 9 — NPI — Billing Provider

Enter the billing provider's NPI.

SECTIONS II A, II B, II C, or II D

Providers are required to complete *one* of either Section II A, II B, II C, or II D or Section V 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 that apply to the member's medical condition. Include the last date of therapy treatment in the chronic lung disease section. For a pre-term infant, the gestational age at delivery must be included.

SECTION II A — CLINICAL INFORMATION FOR CHRONIC LUNG DISEASE

Element 10

Indicate whether or not the member is a child younger than 24 months of age at the start of the respiratory syncytial virus (RSV) season with chronic lung disease who required bronchodilator, corticosteroid, diuretic, or supplemental oxygen therapy within six months of the start of the RSV season.

SECTION II B — CLINICAL INFORMATION FOR CONGENITAL HEART DISEASE

Element 11

Indicate whether or not the member is a child younger than 24 months of age at the start of the RSV season who has hemodynamically significant cyanotic or acyanotic congenital heart disease and is receiving medication to control congestive heart failure, has moderate to severe pulmonary hypertension, or has cyanotic heart disease.

SECTION II C — CLINICAL INFORMATION FOR IMMUNOCOMPROMISED CHILDREN

Element 12

Indicate whether or not the member is a child younger than 24 months of age at the start of the RSV season with a severe immunodeficiency (i.e., severe combined immunodeficiency [SCID] or advanced acquired immunodeficiency syndrome [AIDS]).

SECTION II D — CLINICAL INFORMATION FOR PRE-TERM INFANTS

Element 13

Indicate the pre-term infant's gestational age at delivery in weeks and days. Check the appropriate box to indicate the member's clinical condition.

Element 14

Indicate whether or not the first dose of Synagis® was administered when the child was hospitalized. Indicate the date the first dose was administered. If the first dose of Synagis® was administered when the child was hospitalized, indicate the date the first dose was administered in MM/DD/CCYY format.

Element 15 — Current Weight — Member

Enter the current weight of child in kilograms.

Element 16 — Date Member Weighed

Enter the date the child was weighed.

Element 17 — Calculated Dosage of Synagis®

Enter the monthly dose of Synagis® in milligrams needed based on the calculation of 15 milligrams per kilogram of body weight.

SECTION IV — AUTHORIZED SIGNATURE

Element 18 — Signature — Prescriber

The prescriber is required to complete and sign this form.

Element 19 — 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 20

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

SECTION VI — INTERNAL USE ONLY

This section is for internal use only.