

**VIRGINIA MEDICAID's  
SYNAGIS®  
SERVICE AUTHORIZATION**  
Season: October 1 through March 31



**COMMONWEALTH of VIRGINIA**  
*Department of Medical Assistance Services*

**PATIENT INFORMATION**

Patient's Name:	Patient's Diagnosis:
Patient's Medicaid ID#: (12 digits)	Patient's Weight (kg)
Patient's Date of Birth:	Patient's Gestational Age: _____ wks _____ days

**DRUG/CLINICAL INFORMATION**

Drug Name & Strength:	Quantity Per Month:
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**Check applicable age, condition and risk factors**

- Gestational age < 28 wks, 6 days & infant is < 12 monthst
- Gestational age 29 wks, 0 days-31 wks, 6 days & infant is < 6 monthst
- Gestational age 32 wks, 0 days-34 wks, 6 days & infant is < 3 months old at start of RSV season OR born during the RSV season with one or more of the two AAP risk factors (check all applicable risk factors)
  - childcare attendance
  - sibling younger than 5 years of age

- Gestational age < 35 wks & infant < 12 monthst with congenital abnormalities of the airway or neuromuscular disease that compromises handling of respiratory secretions\*
- Child is < 24 monthst old with Chronic Lung Disease\* of prematurity (gestational age < 35 wks)
- Child is < 24 monthst old with hemodynamically significant Congenital Heart Disease\* (without surgical correction)

† Chronological age at start of RSV season

\* Include ICD-9codes for the indicated disease states. For CLD/CHD, attach supporting documentation (i.e., progress notes, discharge notes, and/or chart notes).

**AND**

Is patient currently outpatient with no inpatient stay in the last 2 weeks?  Yes  No If no, indicate discharge date. \_\_\_\_\_

Was a dose of Synagis® administered while patient was hospitalized?  Yes  No If yes, indicate date dose administered \_\_\_\_\_

**Medical justification/ Documentation for diagnoses not listed.**

**PRESCRIBER INFORMATION**

Physician's Name (print):	Today's Date:
Physician's Signature:	Phone #: ( )
Physician's National Provider ID #:	Fax #: ( )

**PLEASE INCLUDE ALL REQUESTED INFORMATION  
INCOMPLETE FORMS WILL DELAY THE SERVICE AUTHORIZATION PROCESS**

**FAX FORM TO 800-932-6651**

SERVICE AUTHORIZATION CRITERIA ARE SUBJECT TO CHANGE AND THUS DRUG COVERAGE. SUBMISSION OF DOCUMENTATION DOES NOT GUARANTEE COVERAGE BY THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES. FINAL COVERAGE DECISIONS MAY BE AFFECTED BY SPECIFIC MEDICAID LIMITATIONS.