ForwardHealth
Wisconsin serving you

Update
October 2009

No. 2009-71

Affected Programs: BadgerCare Plus, Medicaid, SeniorCare
To: Dentists, Federally Qualified Health Centers, Home Health Agencies, Nurses in Independent Practice, Nurse Practitioners, Nursing Homes, Pharmacies, Physician Assistants, Physician Clinics, Physicians, Podiatrists, Rural Health Clinics, HMOs and Other Managed Care Programs

Revised Prior Authorization Drug Attachment for Synagis® Form and Completion Instructions

ForwardHealth has revised the Prior Authorization Drug Attachment for Synagis®, F-00142 (10/09), to correct the listed weight range table and to clarify clinical criteria for pre-term infants.

ForwardHealth has revised the Prior Authorization Drug Attachment for Synagis®, F-00142 (10/09), to correct an incorrectly listed weight range table and clarify clinical criteria for pre-term infants born at or greater than 32 weeks gestation to less than 35 weeks gestation. Providers may refer to Attachments 1 and 2 of this *ForwardHealth Update* for the revised completion instructions and form.

Corrected Weight Range Table for Synagis®

The following table lists the corrected weight range, the calculated Synagis® dose, and the number of 50 mg units of Synagis®. The table is used for the adjudication of prior authorization (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.

Prior Authorization Amendments

The Drug Authorization and Policy Override (DAPO) Center reviewed all approved PAs to determine whether or not the corrected weight ranges resulted in a change in the number of Synagis® units. The DAPO Center amended approved PAs, if appropriate, and notified providers that their PAs were amended.

Clarified Clinical Criteria

The Prior Authorization Drug Attachment for Synagis did not specify that pre-term infants born at or greater than 32 weeks gestation to less than 35 weeks gestation includes infants that are less than 3 months of age at the start of the respiratory syncytial virus (RSV) season and infants are born during the RSV season.

The Microsoft Word® and Portable Document Format version of the Prior Authorization Drug Attachment for Synagis has been revised and is available for printing from the Forms page of the Portal. The revised version of the form will be available to complete on the Portal in the near future.

Information Regarding Managed Care Organizations

This *Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis only. For managed care policy, contact the appropriate managed care organization. Managed care organizations are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *www.forwardhealth.wi.gov/*.

P-1250

ATTACHMENT 1
Prior Authorization Drug Attachment for Synagis® Completion Instructions

(A copy of the "Prior Authorization Drug Attachment for Synagis® Completion Instructions" is located on the following pages.)

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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.

ATTACHMENT 2
Prior Authorization Drug Attachment for Synagis®

(A copy of the "Prior Authorization Drug Attachment for Synagis®" is located on the following pages.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00142 (10/09)

STATE OF WISCONSIN
DHS 107.10(2), 152.06(3)(h), Wis. Admin. Code
DHS 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION DRUG ATTACHMENT FOR SYNAGIS®

Instructions: Type or print clearly. Refer to the Prior Authorization Drug Attachment for Synagis® Completion Instructions, F-00142A, for more information.

Providers may call the Drug Authorization and Policy Override Center at (800) 947-9627 with questions.

SECTION I — MEMBER AND PROVIDER INFORMATION

1. Name — Member (Last, First, Middle Initial)

2. Member Identification Number	3. Date of Birth — Member
4. Name — Prescriber	5. National Provider Identifier (NPI) — Prescriber
6. Address — Prescriber (Street, City, State, ZIP+4 Code)	7. Telephone Number — Prescriber
8. Name — Billing Provider	9. NPI — Billing Provider

Providers are required to complete *one* of either Section II A, II B, II C, or II D (depending on the member's medical condition) for a prior authorization (PA) request to be considered for approval.

SECTION II A — CLINICAL INFORMATION FOR CHRONIC LUNG DISEASE

10. 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 one of the therapies below within six months of the start of the RSV season. (Chronic lung disease is not asthma, croup, recurrent upper respiratory infections, chronic bronchitis, chronic bronchiolitis, or a history of previous RSV infections.) ❑ Yes ❑ No

    Check all therapies below that the member has tried within the past six months.

    ❑ Bronchodilator ❑ Corticosteroid ❑ Diuretic ❑ Supplemental Oxygen

SECTION II B — CLINICAL INFORMATION FOR CONGENITAL HEART DISEASE

11. The member is a child younger than 24 months of age at the start of the RSV season with 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. ❑ Yes ❑ No

SECTION II C — CLINICAL INFORMATION FOR IMMUNOCOMPROMISED CHILDREN

12. 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]). ❑ Yes ❑ No

SECTION II D — CLINICAL INFORMATION FOR PRE-TERM INFANTS

13. Indicate the pre-term infant's gestational age at delivery (in weeks and days).

    _____ Weeks _____ Days

Continued

DT-PA083-083

SECTION II D — CLINICAL INFORMATION FOR PRE-TERM INFANTS (Continued)

Check one:

- ❑ The member is an infant born before 29 weeks gestation (i.e., zero days through 28 weeks, six days) who is less than 12 months of age at the start of the RSV season.
- ❑ The member is an infant born at or greater than 29 weeks gestation to less than 32 weeks gestation (i.e., 29 weeks, zero days through 31 weeks, six days) who is less than 6 months of age at the start of the RSV season.
- ❑ The member is an infant born at or greater than 32 weeks gestation to less than 35 weeks gestation (i.e., 32 weeks, zero days through 34 weeks, six days) who is less than 3 months of age at the start of the RSV season or was born during the RSV season *and* has at least one of the following risk factors: (Check all that apply.)
  - ❑ The infant attends daycare.
  - ❑ The infant has siblings younger than 5 years of age.
- ❑ The member is an infant born before 35 weeks gestation (i.e., 34 weeks, six days) who is less than 12 months of age at the start of the RSV season with either congenital abnormalities of the airway or a neuromuscular condition that compromises handling of respiratory secretions.

SECTION III — ADMINISTRATION INFORMATION

14. Was the first dose of Synagis® administered when the child was hospitalized? ❑ Yes ❑ No

If yes, indicate the date of administration in the space provided. (No more than five doses will be authorized, inclusive of any hospital-administered doses.)

15. Current Weight — Member (In kilograms)	16. Date Member Weighed

17. Calculated Dosage of Synagis® (15 milligrams per kilogram of body weight)

SECTION IV — AUTHORIZED SIGNATURE

18. **SIGNATURE** — Prescriber	19. Date Signed — Prescriber

SECTION V — ADDITIONAL INFORMATION

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

Number of units (50 mg) per dose: _____

Number of doses approved: _____

Initial units (50 mg) approved: _____

Dates of approval: _____ to _____