HealthPlan OF SAN MATEO
Healthy is for everyone

Prescription Drug Prior Authorization or Step Therapy Exception Request Form

Plan/Medical Group Name: HEALTH PLAN OF SAN MATEO **Plan/Medical Group Phone:** 650-616-2088

Plan/Medical Group Fax: 650-829-2045 **Non-Urgent** ☐ **Exigent Circumstances** ☐

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step-therapy exception request.
Information contained in this form is Protected Health Information under HIPAA.

Patient Information					
First Name:	Last Name:		MI:	Phone Number:	
Address:	City:		State:	Zip Code:	
Date of Birth:	☐ Male ☐ Female	Circle unit of measure Height (in/cm): _____ Weight (lb/kg):_____		Allergies:	
Patient's Authorized Representative (if applicable):		Authorized Representative Phone Number:			
Insurance Information					
Primary Insurance Name:		Patient ID Number:			
Secondary Insurance Name:		Patient ID Number:			
Prescriber Information					
First Name:	Last Name:		Specialty:		
Address:	City:		State:	Zip Code:	
Requestor (if different than prescriber):		Office Contact Person:			
NPI Number (individual):		Phone Number:			
DEA Number (if required):		Fax Number (in HIPAA compliant area):			
Email Address:					
Medication / Medical and Dispensing Information					
Medication Name:					
☐ New Therapy ☐ Renewal ☐ Step Therapy Exception Request If Renewal: Date Therapy Initiated:		Duration of Therapy (specific dates):			
How did the patient receive the medication? ☐ Paid under Insurance Name:_____ Prior Auth Number (if known):_____ ☐ Other (explain):					
Dose/Strength:	Frequency:	Length of Therapy/#Refills:		Quantity:	
Administration: ☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:					
Administration Location: ☐ Physician's Office ☐ Ambulatory Infusion Center	☐ Patient's Home ☐ Home Care Agency ☐ Outpatient Hospital Care	☐ Long Term Care ☐ Other (explain):_____			

Prescription Drug Prior Authorization or Step Therapy Exception Request Form

Patient Name: ID#:

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step therapy exception request.

1. Has the patient tried any other medications for this condition? ☐ **YES** (if yes, complete below) ☐ **NO**

Medication/Therapy (Specify Drug Name and Dosage)	Duration of Therapy (Specify Dates)	Response/Reason for Failure/Allergy

2. List Diagnoses:	**ICD-10:**

3. Required clinical information - Please provide all relevant clinical information to support a prior authorization or step therapy exception request review.

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information related to exigent circumstances, or required under state and federal laws.

☐ Attachments

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date**: _____

Plan/Insurer Use Only Date/Time Request Received by Plan/Insurer: _____ Date/Time of Decision: _____

Fax Number: _____

☐ Approved ☐ Denied Comments/Information Requested: _____

HealthPlan OF SAN MATEO

Covered Synagis (palivizumab) Indications: Optional Worksheet 2020-2021

This is an **optional worksheet** form that may be helpful as a reference guide to determine if your patient has a covered Synagis indication based on the recommendations from the 2014 AAP guidelines for RSV prophylaxis. While not mandatory, you are highly encouraged to submit this optional worksheet in addition to the required HPSM Prescription Drug Prior Authorization or Step Therapy Exception Request Form (pages 1-2 of this document). For your reference, the required prior authorization request form is also available online at the following URL: www.hpsm.org/pharmacy-authorization-request-form.pdf

Patient Name:.....

Date of Birth:..... HPSM#:.....

Physician Name:.....

Current Weight:.....

Gestational Age at Birth:.....

Synagis Dose (at 15 mg/kg):.....

Please confirm that the patient has one of the following covered Synagis indications (based on documented RSV risk factors):

- ☐ Infants born before 29 weeks, 0 days' gestation who are younger than 12 months of age as of November 1st.
- ☐ During the first year of life for preterm infants who develop chronic lung disease (CLD) of prematurity, defined as gestational age less than 32 weeks, 0 days, and a requirement for more than 21% oxygen for at least the first 28 days after birth.
- ☐ During the second year of life for preterm infants with CLD as defined above and continue to require medical therapy (chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) within 6 months before the start of the second RSV season.
- ☐ Infants 12 months of age or younger with acyanotic heart disease, who are receiving medication to control congestive heart failure and will require cardiac surgical procedures or if continues to need medication for congestive heart failure despite surgery and infants with moderate to severe pulmonary hypertension.
- ☐ Infants younger than 12 months of age with cyanotic heart disease may receive Palivizumab prophylaxis if warranted by the infant's pediatric cardiologist.
- ☐ Children younger than 24 months of age who undergo cardiac transplantation during the RSV season.
- ☐ An infant younger than 24 months of age receiving prophylaxis who undergoes cardiopulmonary bypass or extracorporeal membrane oxygenation and continues to require prophylaxis post-operatively may receive a post-operative dose of Palivizumab (15mg/Kg).
- ☐ An infant younger than 12 months of age with neuromuscular disease or congenital anomaly that impairs the ability to clear secretions from the upper airway because of ineffective cough.
- ☐ The children younger than 24 months of age who are profoundly immunocompromised during the RSV season, (e.g., solid organ or hematopoietic stem cell transplantation, chemotherapy, severe combined immunodeficiency, chronic granulomatous disease) as assessed by a qualified pediatric Infectious Disease or Immunologic specialist.
- ☐ During the first year of life, infants with cystic fibrosis who have clinical evidence of CLD of prematurity and/or nutritional compromise.
- ☐ Children younger than 24 months with cystic fibrosis who have either of the following in addition to the CLD of prematurity or nutritional compromise: manifestations of severe lung disease (previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest radiography or chest CT persist when stable) OR weight for length less than the 10th percentile.

Before submitting the required HPSM Prescription Drug Prior Authorization or Step Therapy Exception Request Form (pages 1-2 of this document), please confirm that your Synagis request includes the following minimum pieces of clinical information:

- Patient's current weight
- Patients gestational age at birth
- Patient's Synagis dose (dose is 15mg/kg)
- Patient's diagnosis
- Patient's covered Synagis indication

For assistance, please call **650-616-2088**.