

## SPECIALTY MEDICATION PRIOR AUTHORIZATION FORM

Complete this form and send information to Sunshine Health, Pharmacy Department fax at **1-866-351-7388** For questions, please call **1-866-796-0530**, Ext 41919

## Synagis®

Weight Change Form Note: Form must be completed in full. An incomplete form may be returned.

- Any dosage increase must have corresponding weight charts and/or progress notes with current weight.
- If the dose needed is less than 5 mg over the approved vial size, round down to the nearest vial size. If the dose needed is ≥ 5 mg over the approved vial size, then the new vial size will be approved. For those patients who are expected to gain enough weight to need an additional vial, please schedule a visit to obtain weight & receive approval for dose increase prior to the Synagis® administration date. There are no immediate approvals for "waiting" patients.
- In cases where immediate administration of medication is required, providers should use the currently authorized vial size(s), then submit a weight change request, which will be applied to subsequent dosages only.

Recipient's Medicaid ID#	Date of Birth (MM/DD/YYY)	Y)
Recipient's Full Name		
Prescriber's Full Name		
Prescriber License # (ME, OS, ARNP, PA)		
Prescriber Phone Number		Prescriber Fax Number
Pharmacy Name		
Pharmacy Medicaid Provider #		
Pharmacy Phone Number		Pharmacy Fax Number
1. Previous Weight:	lbs or	_ kgs
2. Current Weight:	lbs or	_ kgs
3. New Dose Required:		
Prescriber's Signature:		DATE:
<b>REQUIRED FOR REVIEW:</b> Copies of medical records (i.e., diagnostic evaluations and recent chart notes), a copy of the		

**<u>REQUIRED FOR REVIEW</u>**: Copies of medical records (i.e., diagnostic evaluations and recent chart notes), original prescription, and the most recent copies of related labs

The provider must retain copies of all documentation for five years.