DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
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Strong Families - South Dakota's Foundation and Our Future

SYNAGIS/RESPIGAM PRIOR AUTHORIZATION

Patient Name:_____DOB:_____Medicaid #: _____

Provider Name:_____Provider #_____Location: _____

Contact Person:_____Phone#:_____Fax#: _____

Synagis and Respigam are covered by the South Dakota Medicaid Program when a child meets one of the following criteria and **it has been recommended by a Neonatologist, Pediatric Pulmonologist, or Pediatric Cardiologist:**

☐ A Children under 6 months of age at the onset of the RSV season who were 32 weeks or less gestational age at birth.

☐ B Children under 3 months of age at the onset of the RSV season or who are born during the RSV season (11/01-03/31) who were between 32 and 35 weeks gestational age at birth with one of these 2 risk factors: Day care attendance or A sibling in the household less than 5 years ofage.

☐ C Children under 2 years of age at the onset of the RSV season with evidence of ongoing lung disease such as bronchopulmonary dysplasia or cystic fibrosis requiring treatment with oral bronchodilators, supplemental oxygen, diuretics, or nebulized or inhaled medications to stabilize the disease in the last 6 months.

☐ D Children under 2 years of age at the onset of the RSV season with evidence of hemodynamically significant cyanotic or acynatotic congenital heart disease and one of the following: Receiving medication to control congestive heart failure; Moderate to severe pulmonary hypertension, or Undergoing surgical procedures that use cardiopulmonary bypass.

☐ E Children under two years of age at the onset of the RSV season with immunodeficiencies that may make them more susceptible to severe lower respiratory tract disease related toRSV.

☐ F Any child under 2 years of age at the onset of the RSV season felt to be at high risk for significant lower respiratory tract illness related to RSV.

Diagnosis: _____

Hospitalizations/Treatment/Medications Used in the last 6 months:

Gestational age at birth: _____

Neonatologist, Pediatric Pulmonologist, or Pediatric Cardiologist: (REQUIRED)

Printed Name:_____**Signature:**_____