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STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Clinical Standards Office
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Kapolei, Hawaii 96709-0190

August 28, 2008

MEMORANDUM ACS M08-11

TO: Medicaid Fee-For-Service (FFS) and QUEST Physicians and Pharmacies

FROM: Kenneth S. Fink, MD, MGA, MPH
Med-QUEST Division Administrator

Anthea Wang, MD, MPH
Med-QUEST Division Medical Director

SUBJECT: Fee-For-Service and QUEST Programs

PREVENTION OF SERIOUS LOWER RESPIRATORY TRACT INFECTIONS CAUSED BY RESPIRATORY SYNCYTIAL VIRUS (RSV)

This memorandum updates and supercedes previous guidelines for the coverage of RSV prophylaxis.

Synagis® (Palvizumab) administered intramuscularly, is approved by the Federal Drug Administration (FDA) for the prevention of serious lower respiratory tract infections in infants. The guidelines that follow were developed based on Hawaii's experience with Synagis®.

The following guidelines for the prevention of RSV and coverage of Synagis® by the Hawaii QUEST medical plans and the Fee-For-Service (FFS) Medicaid program have been developed by the medical directors of the QUEST medical plans and the Med-QUEST Division (MQD). They are based on the guidelines for prophylaxis of RSV infections in high risk infants in Hawaii developed by the Consensus Committee during its meeting on July 15, 2008. The Consensus Committee is comprised of physicians associated with the Department of Pediatrics of the University of Hawaii, School of Medicine with expertise in RSV infections in Hawaii.

General Prevention

Parents and caregivers of former premature infants, infants with bronchopulmonary dysplasia, and infants with congenital heart disease should receive education in the following:

- Strict hand washing techniques;
- Avoidance of unnecessary exposure of their infants to crowds;
- Avoidance of exposure to their infants to smoke and dust, especially passive smoke exposure in presence of smokers in the family; and
- Avoidance of exposure of their infants to all sick persons, especially those with respiratory symptoms.

Patient Population

Patients who should be considered for RSV prophylaxis should be in one or more of the following groups:

- Infants and children younger than two (2) years of age at the start of the RSV season with Chronic Lung Disease (CLD) requiring significant medical therapy, such as oxygen for treatment of their CLD, within six (6) months before the anticipated RSV season (born on or after September 15, 2006; continuing medical treatment after March 15, 2008).
- Infants and children younger than two (2) years of age at the start of the RSV season with hemodynamically significant Congenital Heart Disease (CHD) requiring medical management within six (6) months before the anticipated RSV season (born on or after September 15, 2006; continuing medical treatment after March 15, 2008). Infants younger than 12 months with CHD who are most likely to benefit from immunoprophylaxis include:
  - Infants who are receiving medication to control congestive heart failure;
  - Infants with moderate to severe pulmonary hypertension; and
  - Infants with cyanotic heart disease.
- Infants born prematurely at 28 weeks gestation or earlier and who are less than 12 months chronological age at the start of the RSV season (born on or after September 15, 2007).
- Infants born prematurely between 29 and 32 weeks gestation and who are less than six (6) months chronologic age at the start of the RSV season (born on or after March 15, 2008). The definition of 32 weeks is an infant born on or before the 32nd week of gestation (i.e., 32 + 0 weeks).
- Infants born prematurely between 33 and 35 weeks gestation requiring significant respiratory support in the neonatal period (positive pressure support) and having at least one (1) of the following additional risk factors – day care attendance, school-aged siblings, congenital abnormalities of the airways, or severe neuromuscular disease – and who are less than six (6) months chronological age at the start of the RSV season (born on or after March 15, 2008).

- There are several children with other illnesses in the Pediatric age group who may be considered for prophylaxis. Pediatricians should evaluate these children on a case-by-case basis and, if necessary, in consultation with an appropriate sub-specialist.
- All children after cardiopulmonary bypass and with indication for use of Synagis® should be considered for additional prophylaxis after discharge. Children with cardiac disease undergoing cardiopulmonary bypass during the season and currently receiving prophylaxis should receive an additional dose of prophylaxis within a few days after bypass and should continue to receive subsequent prophylaxis until the end of the season.

RSV Season

RSV infections occur in the community all year round. Based on available epidemiological data, the incidence is significantly higher from September to February. Therefore, the season for late 2008 to early 2009 this year for Hawaii will be from **September 15, 2008 to February 28, 2009**. The Consensus Committee will meet again in late January 2009 to evaluate, utilizing available data, whether or not the RSV season needs to be extended.

Recommended Prophylaxis

- Prophylaxis should start no earlier than September 15, 2008 and end no later than February 28, 2009. A maximum number of five (5) doses will be covered for the identified regular season. Coverage for Synagis® for an additional dose per month will be allowed after February 28, 2009 only if the RSV season is extended by the Consensus Committee.
- The interval between the first and second dose should be no less than and as close as possible to 28 days. All subsequent dose intervals should be as close as possible to 30 days with the range being 28-35 days.
- When children meet criteria for prophylaxis based on their age, prophylaxis should be continued for the duration of the RSV season.
- Should a child develop RSV during the course of the season, prophylaxis should resume after recovery until the end of the season.

Additional Considerations

- The MQD requires authorization for Synagis®. For FFS providers, authorization must be obtained from Affiliated Computer Services (ACS), the MQD's pharmacy fiscal agent. Requests for prior authorization should be faxed on the 1144B (Attachment 1) to 1-888-335-8474. For QUEST providers, authorizations for Synagis® must be obtained from the child's QUEST medical plan.

- Prior authorization will cover Synagis® doses in intervals of 28-35 days during the RSV season from September 15, 2008 to February 28, 2009. If the season is extended by the Consensus Committee, the end date on the prior authorization will be changed to reflect the end date specified by the committee, and additional doses will then be covered up to the revised end date. A second prior authorization will *not* be required.
- Families should be educated that although prophylaxis is not 100% effective, it may lead to a decrease in severity of subsequent illness. Consideration should be given to obtaining an informed consent prior to drug administration.
- Vulnerable children meeting criteria for RSV prophylaxis should also be considered for influenza vaccine in addition to RSV prophylaxis if they are over the age of six (6) months.
- As Synagis® is given intramuscularly, it must be used with caution in patients with thrombocytopenia and coagulation disorders.

Attachment

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

ACS – Hawaii Sate Medicaid Fee for Service Program
Attn: DUR, P.O. Box 967
Henderson, NC 27536-0967

REQUEST FOR MEDICAL AUTHORIZATION

Check only One – Different Types of Services Must Be Requested on Separate 1144B Forms. [ ] Home Infusion PA [ ] Non-home infusion (Medication only) PA

NOTE: INCOMPLETE FORM WILL DELAY THE AUTHORIZATION PROCESS. Approval of this request is not an authorization for payment or an approval of charges. Payment by the Medicaid Program is contingent on the patient being eligible and the provider of service being certified by Medicaid. The provider of service must verify patient eligibility at the time the service is rendered. Authorization expires 60 days from date of approval unless otherwise noted by the consultant.

[1] Medicaid ID Number	[2] Recipient's Name (Last, First, M.I.)	[3] Gender [ ]M [ ]F	[4] Date of Birth / /
[5] Medicare Coverage? [ ]Yes [ ]No Is Patient receiving Medicare Home Health Benefits? [ ]Yes [ ]No	[6] Currently at: [ ] Home [ ] Hospital [ ] SNF/ICF/ICF-MR Facility Recipient's Mailing Address (St., City, Zip Code)	[7] Expanded Early & Periodic Screening Diagnosis & Treatment (EPSDT): [ ] Yes [ ] No	

	Physician Section		Supplier Section (Circle Rent or Repair)			
	[8] NDC Number or Drug Name, Strength, Units, Global Code, or HCPCS code	[9] QTY	[10] Purchase Price	[11] Rent/Repair	[12] Period Requested From:	To:
1						
2						
3						
4						
5						

Physician Section

[13] Diagnosis or ICD-9 code

[14] BMI (for anorexiants):

[15] Period Requested

[16] Prognosis

[17] Justification (include history of previous treatment) ([ ] Attachment)

[18] Print Prescriber's Name/Mailing Address

[19] Prescriber's Signature

[20] Prescriber's NPI

[21] Date

[22] Telephone #

[23] Fax #

[24] Contact Name

Supplier Section

[25] Print Supplier's Name/Mailing Address

[26] Comments

[27] Contact Name

[28] Telephone #

[29] Fax #

[30] Supplier's Signature

[31] Supplier's NPI

[32] Date

DHS 1144B (Rev. 03/07)

FORM INSTRUCTIONS
DHS 1144B (Rev. 03/07)
Request for Medical Authorization of Home Infusion or Medication Prior Authorization (PA)

PURPOSE:
Fee For Service program request for medical authorization of home infusion or medication PA.

FORM INSTRUCTIONS:
1. **Medicaid ID Number:** Enter the Medicaid I.D.
2. **Recipient's Name:** Enter the recipient's name (Last, First, MI).
3. **Gender:** Check the recipient's gender.
4. **Date of Birth:** Enter the recipient's date of birth: mm/dd/yyyy.
5. **Medicare Coverage:** Check whether the recipient has Medicare coverage and is receiving Medicare Home Health Benefits.
6. **Currently At:** Check where the recipient is currently located and enter the mailing address.
7. **Expanded Early & Periodic Screening Diagnosis & Treatment (EPSDT):** Check whether the recipient has received expanded early and periodic screening diagnosis & treatment.
8. **NDC Number or Drug Name, Strength, Units, or Global Code, or HCPCS:** Enter the NDC Number and units or Drug Name with strength and units, or Global Code and units, or HCPCS Code and units.
9. **QTY:** Enter the quantity.
10. **Purchase Price:** Enter the purchase price.
11. **Rent/Repair:** Circle whether this request is for rent or repair and enter the amount.
12. **Period Requested:** Enter the Period Requested From: and To:.
13. **Diagnosis or ICD-9 code:** Enter the diagnosis code or the ICD-9 code.
14. **BMI (for anorexiants):** Enter the BMI.
15. **Period Requested:** Enter the period requested.
16. **Prognosis:** Enter the prognosis.
17. **Justification:** Enter the justification and include any history of previous treatment. Check if any attachments are included.
18. **Print Prescriber's Name / Mailing Address:** Print the prescriber's name and mailing address.
19. **Prescriber's Signature:** Prescriber's: Sign the form.
20. **Prescriber's NPI:** Enter the prescriber's National Provider Identifier (NPI).
21. **Date:** Enter the date of signature.
22. **Telephone #:** Enter the prescriber's telephone number.
23. **Fax #:** Enter the prescriber's fax number.
24. **Contact Name:** Enter the name of the person to contact.
25. **Print Supplier's Name / Mailing Address:** Print the supplier's name and mailing address.
26. **Comments:** Enter any comments.
27. **Contact Name:** Enter the name of the person to contact at the supplier.
28. **Telephone #:** Enter the supplier's telephone number.
29. **Fax#:** Enter the supplier's fax number.
30. **Supplier's Signature:** Sign the request.
31. **Supplier's NPI:** Enter the supplier's or pharmacy's NPI.
32. **Date:** Enter the date of signature.

FILING INSTRUCTIONS:
1. Retain the original hard copy and submit by fax to ACS at 1(888)335-8474;

OR

2. Retain a copy and submit by mail the original hard copy to:

ACS
Hawaii State Medicaid Fee for Service Program
Attn: DUR
P.O. Box 967
Henderson, NC 27536-0967