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STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Clinical Standards Office
P. O. Box 700190
Kapolei, Hawaii 96709-0190

September 8, 2011

MEMORANDUM

MEMO NOS.
ACS M11-09
ADM-1109
ADMX-1109

TO: Medicaid Fee-For-Service (FFS), QUEST, QUEST Expanded Access (QExA), Physicians and Pharmacies

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

SUBJECT: FEE-FOR-SERVICE, QUEST, AND QEXA PROGRAMS
PREVENTION OF SERIOUS LOWER RESPIRATORY TRACT INFECTIONS
CAUSED BY RESPIRATORY SYNCYTIAL VIRUS (RSV)

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

The following guidelines for the prevention of RSV and coverage of palvizumab by the Hawaii QUEST and QUEST Expanded Access (QExA) health plans and the Fee-For-Service (FFS) Medicaid Program have been developed by the Med-QUEST Division (MQD) in partnership with the Hawaii RSV Consensus Committee. The Consensus Committee is comprised of a broad representation of physicians with expertise in RSV infections in Hawaii, and its recommendations are based on the American Academy of Pediatrics national recommendations adjusted for local RSV epidemiology. The RSV season this year for Hawaii will be considered from **September 15, 2011 through March 31, 2012**.

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 of 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.

Recommended Immunoprophylaxis

RSV immunoprophylaxis with Palvizumab (Synagis®) administered intramuscularly at a dosage of 15 mg/kg is approved by the Federal Drug Administration (FDA) for the prevention of serious lower respiratory tract infections in infants and children.

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.

*The following populations should receive a maximum of **five (5)** doses:*

- Infants and children younger than two (2) years of age at the start of the RSV season with chronic lung disease requiring significant medical therapy such as oxygen for treatment, within six (6) months before the anticipated RSV season. (Born on or after September 15, 2009; continuing medical treatment after March 15, 2011).
- Infants and children younger than two (2) years of age at the start of the RSV season who have hemodynamically significant congenital heart disease or persistent moderate to severe pulmonary hypertension. (Born on or after September 15, 2009; ongoing medical treatment).
- Infants born prematurely at 28 6/7 weeks gestation or earlier and who are less than twelve (12) months chronological age at the start of the RSV season. (Born on or after September 15, 2010).
- Infants born prematurely between 29 0/7 and 31 6/7 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, 2011).

*The following population should receive a maximum of **three (3)** doses:*

- Infants born prematurely between 32 0/7 and 34 6/7 weeks gestation and who are less than three (3) months chronological age at the start of the RSV season (born on or after June 15, 2011), who required significant respiratory support in the neonatal period including significant positive pressure support (i.e., ventilator, continuous positive airway pressure or high flow nasal cannula) and an oxygen requirement above 30% in the first seventy-two (72) hours of life, and who have the additional risk factor of either day care attendance or sibling less than five (5) years of age.

Other clinical considerations:

- Children with cardiac disease receiving RSV immunoprophylaxis who undergo cardiopulmonary bypass during the season should receive an additional dose of palivizumab as soon as medically stable following surgery and should continue to receive subsequent prophylaxis until the end of the season.
- There are several children with other illnesses in the pediatric age group who may be considered for prophylaxis. These children should be evaluated on a case-by-case basis.
- When children meet criteria for prophylaxis based on their age, prophylaxis should continue 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.
- As palvizumab is given intramuscularly, it must be used with caution in patients with thrombocytopenia and coagulation disorders. In addition, although prophylaxis is not 100% effective, it may lead to a decrease in severity of subsequent illness. Informed consent is recommended prior to drug administration.

- Infants and children meeting criteria for RSV prophylaxis should also be considered for influenza vaccine if they are over the age of six (6) months.

Prior Authorization

- The MQD requires authorization for palvizumab. 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 (see attachments) to 1-888-335-8474. For QUEST or QExA providers, authorizations for palvizumab must be obtained from the child's QUEST or QExA medical plan.
- Prior authorization will cover palvizumab doses in intervals of 28-35 days during the RSV season administered between September 15, 2011 and March 31, 2012.

Attachments

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