

Alabama Medicaid Pharmacy Synagis® PA Request Form

FAX: (800) 748-0116
Phone: (800) 748-0130

Fax or Mail to
HEALTH INFORMATION DESIGNS

P.O. Box 3210
Auburn, AL 36832-3210

Incomplete Forms Will Be Returned

PATIENT INFORMATION

Patient Name _____ Patient Medicaid # _____

Patient DOB _____ Patient phone # with area code _____

PRESCRIBER INFORMATION

Prescriber name _____ NPI # _____ License # _____

Phone # with area code _____ Fax # with area code _____

Address (Optional) _____
(Address/City/State/Zip)

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Required supporting documentation from the patient's medical record is attached.

Prescribing Practitioner Signature (Required)

Date

DRUG/CLINICAL INFORMATION

Drug requested _____ NDC/J Code _____

Strength _____ Qty. per month _____ Number of doses requested _____
(if applicable)

Current weight _____ kg. Gestational age _____ wks _____ days Chronological age _____

ICD-9 Codes _____

Check applicable age, condition and risk factors

- Gestational age \leq 28 wks, 6 days & infant is $<$ 12 months[†]
- Gestational age 29 wks, 0 days-31 wks, 6 days & infant is $<$ 6 months[†]
- Gestational age 32 wks, 0 days-34 wks, 6 days & infant is $<$ 3 months old at start of RSV season **OR** born during the RSV season with one or more of the two AAP risk factors (check all applicable risk factors)
 - childcare attendance
 - sibling younger than 5 years of age

- Gestational age $<$ 35 wks & infant \leq 12 months[†] with congenital abnormalities of the airway or neuromuscular disease that compromises handling of respiratory secretions*
- Child is $<$ 24 months[†] old with Chronic Lung Disease* of prematurity (gestational age $<$ 35 wks)
- Child is \leq 24 months[†] old with hemodynamically significant (cyanotic or acyanotic) Congenital Heart Disease* (must not have had or completed surgical correction)

[†] Chronological age at start of RSV season

* Include ICD-9 codes for the indicated disease states. For CLD/CHD, attach supporting documentation (i.e. progress notes, discharge notes, and/or chart notes) as outlined in the criteria for any submitted diagnosis/ICD-9 code.

AND

Is patient currently outpatient with no inpatient stay in the last 2 weeks? Yes No If no, indicate discharge date _____

Was a dose of Synagis® administered while patient was hospitalized? Yes No If yes, indicate date dose administered _____

Medical justification/Reference attached supporting documentation

Medications (include medication name, start date, and end date for diagnoses that require acceptable medical therapy)

PHARMACY INFORMATION

Dispensing pharmacy _____ NPI# _____

Phone # with area code _____ Fax # with area code _____