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

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

ICD-9 Codes _____

Check applicable age, condition and risk factors

- ❒ Gestational age ≤ 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 < 3 months old at the start of RSV season OR born during the RSV season with one of the two AAP risk factors*
- ❒ Gestational age < 35 wks & infant ≤ 12 months† with congenital abnormalities of the airway or neuromuscular disease that compromises handling of respiratory infections**
- ❒ Child is < 24 months† old with Chronic Lung Disease** of prematurity (gestational age < 35 wks)
- ❒ Child is ≤ 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
* Document AAP risk factor(s) below
** Include ICD-9 codes for the indicated disease states. 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 _____

AAP recognized risk factors/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 _____