

**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 _____
(Stamps/copies of physician's signature will not be accepted)

DRUG/CLINICAL INFORMATION

Drug requested _____ NDC/J Code _____

Strength _____ Qty. per month _____ Number of doses requested _____

Current weight _____ kg. as of ____/____/____ Gestational age _____ wks _____ days

ICD-9 Codes _____ Chronological age _____

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 and 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

- Infant is \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 weeks)
- 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.

[‡] Multiple birth siblings younger than 1 year of age do not qualify for this risk factor.

AND

Is patient currently in the hospital? Yes No

Has the patient been in the hospital since the start of the current RSV season (October 1)? Yes No

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

If yes, provide date _____

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 _____