

**Alabama Medicaid Pharmacy
Synagis® PA Request Form**

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

**Fax or Mail to
Kepro**

**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 _____

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

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

ICD-10 Codes _____ Chronological age _____

Check applicable age/condition

- Gestational age < 29 wks, 0 days and chronological age < 12 months old[†]
- Child ≤ 12 months old[†] with pulmonary abnormality or neuromuscular disease that impairs the ability to clear secretions from the upper airway because of ineffective cough
- Child ≤ 12 months old[†] with Chronic Lung Disease* (CLD) of prematurity defined as gestational age less than 32 wks, 0 days and requires supplemental oxygen >21% for at least the first 28 days after birth **
- Child ≤ 24 months old[†] with Chronic Lung Disease* (CLD) of prematurity defined as gestational age less than 32 weeks, 0 days and has received supplemental oxygen >21% for at least the first 28 days after birth** and continues to require medical support (chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) within 6 months before the start of the second RSV season
- Child ≤ 12 months old[†] with hemodynamically significant cyanotic or acyanotic Congenital Heart Disease* (CHD)

[†] Chronological age at start of RSV season.
^{*} Include ICD-10 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-10 code.
^{**} Infants for which documentation indicates weaning was attempted and failed in the 1st 28 days after birth may be approved.

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, please 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 _____