

**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 \_\_\_\_\_

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<sup>†</sup>
- Child ≤ 12 months old<sup>†</sup> 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<sup>†</sup> 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<sup>†</sup> 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<sup>†</sup> 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 1<sup>st</sup> 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 \_\_\_\_\_