Alabama Medicaid Pharmacy
Synagis® PA Request Form

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

Fax or Mail to
Acentra Health

P.O. Box 3570
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

Has the patient received Beyfortus® (nirsevimab) in the current RSV season? ☐ Yes ☐ No
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 _____