



4606

NORTH CAROLINA MEDICAID
PRIOR AUTHORIZATION
Synagis Drug Request
Children less than 21 Years of Age

Request Date

Request date input fields: / /

Recipient's Medicaid ID Number RECIPIENT INFORMATION

Medicaid ID Number input fields

Recipient's Date of Birth

Date of Birth input fields: / /

Recipient's Full Name

Recipient's Full Name input fields

Prescriber's Full Name PRESCRIBER INFORMATION

Prescriber's Full Name input fields

Prescriber Street Address

Prescriber Street Address input fields

City

City input fields

State

State input fields

Zip Code

Zip Code input fields: -

Prescriber Phone:

Prescriber Phone input fields: - -

Prescriber Fax:

Prescriber Fax input fields: - -

Prescriber NPI #

Prescriber NPI # input fields

Prescriber DEA #

Prescriber DEA # input fields: -

Pharmacy Name PHARMACY INFORMATION

Pharmacy Name input fields

Pharmacy Phone:

Pharmacy Phone input fields: - -

Pharmacy Fax:

Pharmacy Fax input fields: - -

Estimated Gestational Age at Birth (in weeks & days) weeks days EGA ICD-9-CM (if available for EGA)

- () Infant or child is <= 24 months of age (DOB must be on or after 11/02/08) AND has one of the following two diagnoses:
() Chronic lung disease (Specify ICD-9-CM) AND required the following therapies in the 6 months before the start of the season:
() supplemental oxygen () diuretic () bronchodilator () chronic corticosteroid therapy
() Hemodynamically Significant Heart Disease (Specify ICD-9-CM)
List current CHD medications
() Infant is < 12 months old (DOB on or after 11/2/09) AND born at EGA <= 28 weeks 6 days
() Infant is < 6 months old (DOB on or after 05/02/10) AND born at EGA 29 weeks 0 days to 31 weeks 6 days
() Infant is within 12 months of age (DOB is after 3/31/10) AND born at EGA <= 34 weeks 6 days AND HAS Compromised handling of respiratory secretions due to () severe neuromuscular disease ICD-9-CM OR () congenital abnormalities of airways ICD-9-CM
() Infant is < 90 days of life (DOB on or after 8/2/10) at start of season or < 90 days of life during the season AND born between 32 weeks 0 days & 34 wks 6 days AND has one of the following defined risk factors:
() Sibling younger than 5 years of age in the home OR () Attends day care (defined as home or facility where care is provided for any number of infants/young toddlers in the home or facility(toddler age is up to third birthday).

If none of the above criteria apply provide justification of medical need for Synagis. Please use ICD-9-CM and describe severity of the diagnoses

THIS FORM IS NOT TAMPER RESISTANT AND MUST BE FAXED TO THE PHARMACY

Rx () 50mg Synagis (palivizumab) () 100mg Synagis (palivizumab)

Directions: 15mg/kg IM monthly
Dispense one month supply

Dosing Information Current Weight lbs or kg
Refill

Signature of Prescriber

*Prescriber signature mandatory

Date input fields: / /

Date

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

FAX TO: NORTH CAROLINA Medicaid Prior Authorizations

Fax: (866)-246-8507

PA HELPDESK: (866) 246 - 8505

4606

