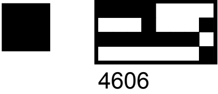

4606

NORTH CAROLINA MEDICAID PRIOR AUTHORIZATION

Synagis Drug Request
Children less than 21 Years of Age

Request Date __ __ / __ __ / __ __ __ __

RECIPIENT INFORMATION

Recipient's Medicaid ID Number

Recipient's Date of Birth __ __ / __ __ / __ __ __ __

Recipient's Full Name

PRESCRIBER INFORMATION

Prescriber's Full Name

Prescriber Street Address

City

State

Zip Code -

Prescriber Phone: - -

Prescriber Fax: - -

Prescriber NPI #

Prescriber DEA # -

PHARMACY INFORMATION

Pharmacy Name

Pharmacy Phone: - -

Pharmacy Fax: - -

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 0days to 31weeks 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

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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 Dosing Information Current Weight ____________lbs or ____________kg

Dispense one month supply Refill _______________

Signature of Prescriber____ Date __ __ / __ __ / __ __ __ __

*Prescriber signature mandatory

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

10/2010