17769

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: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Drug Requested:

Strength _____ **Patient Daily Dose** _____ **Length of Therapy on Prescription** _____

No. of doses requested___ ***(no more than 5 and adjusted if an infant received the drug prior to hospital discharge)***

Starting date requested_____ **Ending date requested**_____

Justification of Medical Necessity for Synagis ***(justification information must be provided)***

_____

_____

_____

_____

_____

EGA (in weeks and days)_____

Supplemental Information -- Check all that apply during last 6 months

_____**Apnea monitor** ____**currently on monitor** ___**not currently on monitor**

_____**Oxygen - Use Frequency** ___**continuous** ____**every night** ___ **only as needed**

_____**Respiratory medications - List** _____

_____**CHD hemodynamically stable** _____ **CHD hemodynamically unstable**

_____**Cardiac medications/diuretics - List** _____

FAX TO: NORTH CAROLINA Medicaid Prior Authorizations

Fax: (866)-246-8507

PA HELPDESK: (866) 246 - 8505

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07/2009