25258

KANSAS MEDICAID
PRIOR AUTHORIZATION
Palivizumab (Synagis®)

Request Date ___ / ___ / ____

BENEFICIARY INFORMATION

Beneficiary Medicaid ID Number

Beneficiary Date of Birth ___ / ___ / ____

Beneficiary Full Name

PRESCRIBER INFORMATION

Prescriber's Full Name

Prescriber Street Address

City

State

Zip Code -

Prescriber Phone: - -

Prescriber Fax: - -

Prescriber Medicaid ID #

Prescriber NPI #

NDC Requested:

Strength _____ Quantity _____ Length of Therapy on Prescription _____

Prescription instructions(sig):_____

In order to determine medical necessity, please complete the following:

1. Child's gestational age at birth: _____
2. Does the child have chronic respiratory disease arising in the perinatal period? _____
   (If yes, please indicate treatment(s), date(s) and diagnosis for the past 6 months:
   _____

3. Does the child have congenital abnormalities of the airway? _____

4. Please indicate if the child has any of the following:
   Moderate-to-severe pulmonary hypertension_____
   Cyanotic CHD and has not had surgical correction_____
   Acyanotic CHD and is receiving medication to control congestive heart failure_____

5. Please indicate if the child has any of the following risk factors:
   __ young siblings/housemates in the home. Age of siblings/housemates in home _____
   __ childcare center attendance_____

6. Child's current weight: _____# OR _____KG

Signature of Prescriber_____ Date ___ / ___ / ____

*Prescriber signature mandatory

FAX TO: **KANSAS Medicaid Prior Authorizations**
Fax: (866) 246-8512
PA HELPDESK: (877) 475 - 7567

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September 2012