19805

KANSAS MEDICAID
PRIOR AUTHORIZATION
Palivizumab (Synagis®) Status

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):_____

( ) Received a Synagis® injection

Date: _____

Current Weight: _____# OR _____KG

( ) Did not receive a Synagis® injection

Reason: ( ) Rescheduled for _____

( ) Spoke with family, need to reschedule

( ) Could not reach the family

Signature of Prescriber_____ ___ / ___ / ____

*Prescriber signature mandatory

Date

FAX TO: **KANSAS Medicaid Prior Authorizations**

Fax: (866) 246-8512

PA HELPDESK: (877) 475 - 7567

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August 2011