



**Kansas Medical Assistance Program**

P O Box 3571  
Topeka, KS 66601-3571  
Provider 1-800-933-6593  
Beneficiary 1-800-766-9012

**Palivizumab (Synagis®) Status  
Prior Authorization Request Form**

Beneficiary Name: \_\_\_\_\_

Beneficiary Medicaid ID #: \_\_\_\_\_ Date Of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Prescribing Physician's Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Physician Medicaid ID#: \_\_\_\_\_ Physician NPI#: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

Ordering Physician or Designee's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Completed form should be faxed to the Prior Authorization Unit at 1-800-913-2229.  
This form will be returned unprocessed if it is not completed in its entirety.**