Summit COMMUNITY CARE

# Summit Community Care Prescription Drug Program
# Synagis® Prior Authorization (PA) Request Form (Year 2019–2020)

**Synagis® (palivizumab) is a humanized monoclonal antibody produced by recombinant DNA technology that is indicated for the prevention of serious lower respiratory tract diseases caused by respiratory syncytial virus (RSV).**

***PRESCRIBER***

For Arkansas, the typical RSV season runs from November 1 to March 31. A maximum of five (5) doses will be approved per beneficiary. The administration of only one dose of Synagis® will be approved per calendar month. The last dose must be administered to the patient before March 31, 2020. The Synagis® Prior Authorization (PA) Request Form is expected to be completed by the prescriber or their assigned staff personnel and signed by the prescriber. Signature of a pre-completed form received by an outside party is not encouraged and may result in an audit. Additional information may be requested, such as a discharge summary.

The recommended Synagis® dose is based on weight at 15 mg/kg. Prescribe minimum units necessary for the dosage. If approved, you will receive a Synagis® Approval confirmation fax requesting the appointment date for the first dose. Authorization for each monthly dose will require submission of the previous month's approval fax with the requested information. At least one week prior to the expected appointment (i.e., not the day of the appointment), the clinic will need to send in verification that the beneficiary does have an appointment scheduled for the administration of Synagis®. Summit Community Care will authorize the appropriate strength and notify you and the pharmacy indicated on the Synagis® PA Request Form that the pharmacy may bill during the authorized dates.

**Please note:** A second RSV season will only be considered for chronic lung disease (CLD) of prematurity based on the 2014 AAP Guidelines: "A second season of palivizumab prophylaxis is recommended only for preterm infants born at < 32 weeks, 0 days' gestation who required at least 28 days of oxygen after birth and who continue to require supplemental oxygen, chronic systemic corticosteroid therapy, or bronchodilator therapy within 6 months of the start of the second RSV season."

***PHARMACY***

Always file claims with the primary insurance before billing Summit Community Care. Synagis® PA approval does not ensure Summit Community Care eligibility. Synagis® dosage is based on 15 mg/kg. Dispense the minimum units necessary for the dosage. Pharmacies will be subject to audit to ensure the NDC(s) dispensed will total the dosage closest to the dosage required. Overbilled units are subject to recoupment. Weight changes requiring PA adjustment can be coordinated with Summit Community Care Pharmacy PA Services. Each PA will be set up one week prior to the expected appointment. The clinic will need to send in verification that the beneficiary does have an appointment scheduled for the administration of Synagis® before the PA for that dose will be entered.

Dispensing Guide:

| **Weight** | **Dosage** | **Dispense Units** |
|---|---|---|
| Up to 3.3 kg | Up to 49.5 mg | 1 x 50 mg vial |
| 3.4 kg to 6.6 kg | 51 mg to 99 mg | 1 x 100 mg vial |
| 6.7 kg to 10 kg | 100.5 mg to 150 mg | 1 x 100 mg vial + 1 x 50 mg vial |
| 10.1 kg to 13.3 kg | 151.5 mg to 199.5 mg | 2 x 100 mg vials |
| 13.4 kg to 16.6 kg | 201 mg to 249.5 mg | 2 x 100 mg vials + 1 x 50 mg vial |
| 16.7 kg to 20 kg | 250.5 mg to 300 mg | 3 x 100 mg vials |

**Note:** Synagis® is to be given every 28–30 days during RSV Season. The 2019–2020 season is November through March. Compliance with all of the specific criteria listed on these pages is a condition for payment by Summit Community Care.

Reset Form Print Form

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**The form on this page is to be COMPLETED by and RECEIVED from the prescribing provider. The form will not be accepted from the providing pharmacy. Please fax this completed form to the Pharmacy PA Center for evaluation and processing.**

**PLEASE COMPLETE ALL SECTIONS**

***Beneficiary Information***

**LAST NAME:** **FIRST NAME:**

**MEDICAID ID NUMBER:** **DATE OF BIRTH:** – –

***Prescriber Information***

**LAST NAME:** **FIRST NAME:**

**NPI NUMBER:** **OFFICE CONTACT:**

**PHONE NUMBER:** – – **FAX NUMBER:** – –

**BIRTH WEIGHT:** _____ **KG** **CURRENT WEIGHT:** _____ **KG** **DATE MEASURED:** - -

**PHARMACY PROVIDER:** _____ **PHARMACY FAX NUMBER:** - -

***Select ONE of the following criteria the patient currently meets to be considered for RSV prophylaxis:***

☐ 1. Chronic lung disease (CLD) of prematurity **AND** < 2 years of age at start of RSV season. CLD of prematurity is defined as gestational of age < 32 weeks, 0 days and a requirement for > 21% oxygen for at least the first 28 days after birth. A second season of palivizumab prophylaxis is recommended only for infants with CLD of prematurity as defined above and who continue to require supplemental oxygen, chronic systemic corticosteroid therapy, diuretic therapy, or bronchodilator therapy during the 6-month period before the start of the second RSV season.

☐ 2. Former premature (≤ 28 weeks, 6 days estimated gestational age (EGA)) **AND** < 12 months of age at the ***start*** of RSV season. For infants born during the RSV season, fewer than 5 monthly doses will be needed.

☐ 3. Infants ≤ 12 months of age at ***start*** of RSV season with hemodynamically significant congenital heart disease (CHD). Children that meet these criteria will be**: a**) infants with acyanotic heart disease who are receiving medication to control congestive heart failure and will require cardiac surgical procedures and **b)** infants with moderate to severe pulmonary hypertension. Infants with cyanotic heart defects in the first year of life will be reviewed on a case-by-case basis.

☐ 4. Infants < 12 months of age at start of RSV season with neuromuscular disease or congenital anomaly that impairs the ability to clear secretions from the upper airway because of ineffective cough.

☐ 5. Severe immunocompromised **AND** patient is < 2 years of age.

**Note: If none of the above criteria are met, an exception request may be submitted in the form of a letter by the prescriber, identifying the patient and documenting the conditions for which the exception is being requested. These letters may be faxed to 1-844-429-7762.

_____ _____

***Prescriber Signature (Required)*** ***Date***

***Prescriber's original signature required; copied, stamped, or e-signatures are not allowed.***

*(By signature, the Physician confirms the above information is accurate and verifiable by patient records.)*

**Pharmacy PA Call Center: 1-844-462-0022**

**Fax: 1-844-429-7762**